



Senate Select Committee on  
**MEDICAID REFORM**

Lisa Carlton, Chair  
Jeffrey Atwater, Vice Chair

This packet contains written comments from the public received during the Medicaid Reform meeting held in ***Fort Lauderdale*** on February 14, 2005.

All comments submitted have been included in their entirety for consideration by members of the Senate Select Committee on Medicaid Reform and the House Select Committee on Medicaid Reform.

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February 14, 2005

This testimony is submitted for the Medicaid hearing being held in Ft. Lauderdale at the Government Center today. I am asking Mrs. Margarita Montalvo and her husband, John Montalvo to please read this, since I cannot be there. I would have given the testimony in person as I deem this extremely important, but my husband is having surgery today at South Miami Hospital and I am with him.

I have recently gone through a Medicaid Waiver Hearing with Maximus and the Agency for Persons with Disabilities of the Department of Children and Families for my daughter Jessica Remrey. I am also Jessica's guardian. My daughter is a 32 year old individual with severe disabilities. Her primary disability is severe mental retardation, although she is legally blind and has a hearing loss. She has been labeled as having Riegger syndrome. Although she has been very healthy most of her life about three years ago Jessica had five double pneumonias in the span of one year. She was evaluated and diagnosed with a swallowing disorder. To continue her quality of life as it had been prior to her illness we put into place various safety measures as per recommended by her doctor. Her feeding and drinking habits would be completely altered and now supervised at all times. Since at the time the District office had power to negotiate with providers directly, at the time the day program paid a person a higher rate to feed Jessica at lunch time and give her liquids with thickener.

When the support plan for 2003 was submitted Jessica's support coordinator was leaving the system. She left in place the best possible solution after many changes had occurred with the Mercer rates. A new coordinator was supposed to come on board to follow up with the new plan. I was very involved in the recuperation of my husband from a heart attack and was not monitoring Jessica's support plan as closely as I should have. No support coordinator contacted me for eight months. Jessica fell ill again and ended up in the hospital for ten days with double pneumonia. She was re-evaluated and her condition had worsened. As we unraveled the support plan it became evident that Jessica had not had the supervision she needed. Her support plan was coming up for revision and with a new coordinator we put into place the more stringent recommendations of her physician. She now needed six smaller meals a day and more stringent supervision.

In this plan was recommended a personal care attendant at her day program. The District office recommended proceeding as written, and if Maximus denied it we would defend it.

I received a letter from Maximus denying Jessica's PCA hours at the day program. I wrote an explanation and requested a hearing. On January 13, 2005 I represented Jessica at this hearing. I could not get representation for Jessica after I had tried the Advocacy Center for Persons with Disabilities, and NINE attorneys that were recommended through the Florida Bar and various advocates. I had tried to get help from my legislators: Alex Villalobos and Larcenia Bullard, the Governor's office and the Statewide Advocacy Committee. No one could help. Only one attorney would take the case for \$3,500. and he was certain he would fail. The appeal in front of an Appellate Judge might be better, but that charge would be from \$7,000.-\$10,000. I don't know of any individuals with disabilities that could afford this. I thought it was ironic that my tax dollars should pay for the Assistant District Attorney to represent the state, and the Maximus witness on the phone to take away my daughter's services when she did not have any representation.

Maximus recommended denying my daughter her services without ever meeting her or seeing her. They based their decision on a rules handbook for Medicaid Waiver that has not been promulgated. The Mercer rates that went into effect in 2003 never delivered on a tool to evaluate the need of the consumer, which is what they were contracted for. Instead they came up with "medical necessity" which must be proven to receive a service. It is more hoops for the consumer and his coordinator to jump through, and they still will deny the service based on some other rule in the handbook. For example, the Asst. State's Attorney did not want to have any of my daughter's hospital reports or doctor's statements entered as evidence because it was irrelevant to medical necessity. That is absurd, but yet the page of the handbook that the decision was based on was that two services could not be approved occurring at the same time: Personal Care Attendant and Day Training Program. No one is looking at the individual we are making decisions about.

In spite of the fact that I had letters from two physicians stating that if Jessica was not supervised at all times they would be forced to put in a feeding tube in her stomach, which they did not recommend, this was not considered. Maximus' solution to supervising my daughter to avoid aspirations was to "strengthen her circle of support", but they would not be responsible if something happened. This leaves me to make the decision of my daughter attending the day program where she has thrived, without the proper supervision OR leaving her home to

increase her chances of remaining healthy, yet unstimulated. About ten years ago I placed Jessica on the Prado-Steinman lawsuit for this very reason. We were being made to choose between two services when she needed both. I don't need to remind you that that lawsuit was won by the respondents and that the state agreed to comply with ALL of the decision. Are Maximus and Mercer aware of this decision and are they choosing to ignore it, hiding behind administrative law? Is the state choosing to ignore this decision to save money on the backs of our children to provide others on the waiting list with services? It is deplorable that we would turn our back on those individuals who are most fragile to make it look like we are serving more individuals who are on a waiting list for services. The fact is that Florida is STILL 49<sup>th</sup> in spending for services to individuals with disabilities in spite of improvements over the last six years.

The state of Florida has a responsibility to its most frail citizens, and our tax dollars need to be reevaluated so that we can step up to the plate and meet the need. Thank you very much.

Sincerely,  
Lourdes Bravo  
12924 SW 113 Ct.  
Miami, FL 33176



Center for Independent  
Living of Broward

*Our Mission is to offer assistance to  
people with disabilities in fulfilling  
the goals of independence  
and self-sufficiency.*

Felix Cruz  
Consumer Specialist

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**Comments for Florida Reforming Medicaid Public Forum**  
**Alan D. Reitman, Ph.D., L.M.H.C., MT-BC**  
Licensed Mental Health Counselor, FL #MH 7872  
Board Certified Music Therapist

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2/14/05

My name is Dr. Alan Reitman and I am a Board-Certified Music Therapist from Hollywood, Florida. I would like to thank Senate President, Tom Lee, and House Speaker, Allan Bense, for this opportunity to offer comments regarding Medicaid Reform in our state. I would also like to thank Representative Eleanor Sobel and the other Representatives in attendance for hosting this public forum.

Music therapy is an established healthcare profession that uses music to address physical, emotional, cognitive, and social needs of individuals of all ages. Music therapy improves the quality of life for persons who are well and meets the needs of children and adults with disabilities or illnesses. Music therapy interventions can be designed to promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication, and promote physical rehabilitation. Approximately 50 years of evidence-based research in music therapy, documented in numerous peer-reviewed professional journals, supports its effectiveness and benefits in a wide variety of healthcare and educational settings.

I would like to request your support for access to cost-effective music therapy services within the Medicaid program. Although music therapists receive training that is equal in rigor to other types of Medicaid-approved non-physician providers (i.e., Speech Therapists, Occupational Therapists, etc.), access to music therapy interventions for Medicaid beneficiaries has been lacking. This, even though Music Therapy has demonstrated its cost effectiveness in a variety of medically-related interventions.

Music therapy may be considered a medically related profession. Like most other therapists, Music Therapists conduct music therapy assessments and document medically related information to substantiate the need for treatment or service recommended. From the assessment, the Music Therapists are also responsible for ongoing re-evaluations of the clinical effectiveness of their interventions. Music Therapists frequently serve on hospital based treatment teams as well as school based IEP teams. They are familiar with and required to complete meticulous professional documentation of their services. Finally, many of the interventions provided by Music Therapists overlap those described in the American Medical Association's "Physician's Current Procedural Terminology" listing (i.e., CPT codes), which are often used for third party reimbursement purposes.

I am providing you with research evidence documenting the clinical effectiveness of music therapy in medicine, as well as a book related to the effectiveness of music therapy procedures. In addition, I have included a book related to current music therapy reimbursement practices. Further information may be found at the American Music Therapy Association's (AMTA) website at [www.musictherapy.org](http://www.musictherapy.org).

In addition to my request for inclusion of music therapy within the Medicaid program, I would like to offer comments regarding the Governor's Medicaid Modernization Proposal. The proposal appears to place the most vulnerable Floridians at risk, leaving critical coverage decisions to managed care organizations alone. It fails to address the underlying causes of health care costs increases, creates a maze for people to navigate, and adds more administrative costs. There is no guarantee that the health plans will be available in rural areas. How will the state ensure that all qualifying Floridians have access to health plans and health care services, including much needed therapeutic services offered by qualified Music Therapists?

Thank you for considering these comments regarding the Governor's proposal and for considering my request for access to cost-effective music therapy services for Medicaid participants. Please feel free to contact myself or Judy Simpson, MHP, MT-BC, Director of Government Relations, American Music Therapy Association, at the enclosed contact numbers.

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Judy Simpson: MHP, MT-BC: (301) 589-3300; [Simpson@musictherapy.org](mailto:Simpson@musictherapy.org)

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**JOINT PUBLIC HEARING ON MEDICAID REFORM**

**TESTIMONY**

**BROWARD COUNTY GOVERNMENTAL CENTER**

**PRESENTED MONDAY, FEBRUARY 14, 2005**

**EDITH LEDERBERG, EXECUTIVE DIRECTOR  
AREA AGENCY ON AGING OF BROWARD COUNTY**

**My name is Edith Lederberg, and I am the Executive Director of the Area Agency on Aging of Broward County, which recently was selected to serve as one of the three Aging and Disability Resource Centers in the State of Florida.**

**Thank you both for scheduling this vitally important gathering, as well as calendaring the hearing in Broward County, which is the year-round home to over 357,067 seniors.**

**We primarily are present today in order to hear the testimony of Medicaid recipients, their caregivers, other professionals, and advocates somehow affected by the current, as well as proposed potential changes in Medicaid Guidelines.**

**However, we would be remiss were we not to state that approximately 5% of Florida's population are Medicaid recipients. Here, in Broward County, our prime problems revolve around determining mechanisms to assist not only low income, but also average income elders and populations who earn slightly more than the annual Medicaid eligible incomes of \$1,737 a month or \$20,844 annually per individual, as well as \$3,474 per month and \$41,688 for a couple yearly.**

**Our waiting lists for services, funded by State Community Care for the Elderly Appropriations exceed 1,100 seniors, and our Alzheimer's Disease Initiative Projects, statewide, have not received an appreciable augment for numerous years. Medicaid does not address these programs for a multitude of seniors.**

**Perhaps, the most appealing feature of Medicaid Waiver is its ability to draw down matching funds from the Federal Government, at approximately 55% Federal to 45% State. The least publicized issue deals with the population "falling through the cracks" because they are neither wealthy enough to support their own needs, especially those associated with medical prescriptions and other health related matters.**

**We believe cost of living should be included when income guidelines for Medicaid eligibility are established. This Area Agency also would like to stress our opinion that Health Maintenance Organizations are a necessary part of the Medicaid solution to a problem facing the State, and we appreciate their existence! However, they are not, and should not be determined to be the only answer. Community based service organization have been the immediate responders to pleas for help during hurricanes and other disasters. The ability to react positively with little notice, to local cries for emergency food and other supplies, has been a blessing available through well established providers who know their communities and have the ability to mobilize staff and volunteers to move quickly to respond, with quality aid, and caring hearts.**

The establishment of Aging Resource Centers, statewide, has been accorded, by State Legislative Action in 2003, to the eleven Area Agencies on Aging. As partners with the Department of Elder Affairs, Children and Families, and the Statewide Provider Network, we are pledged to cooperate with Health Maintenance Organizations and additional health entities, to assure consumer choice rather than consumer mandate.

Quality of service provisions is a major issue that must be considered and evaluated as we reflect about capitated rates. Avoiding premature nursing home placement must be a prime goal of the aging service providers. Once this placement no longer can be avoided, we should assure the nursing homes are receiving sufficient Medicaid Allocations to cover all costs associated with their Medicaid Patients. This presently is not the fact statewide, for about 95% of nursing homes. The result is unfair augments in charges to the private pay patients to keep a multitude of Florida's nursing homes above the deficit level.

If something appears "too good to be true", it probably requires careful consideration. We appreciate the concerns of the State Leadership that Medicaid needs loom dangerously close to bankrupting the Budget, and that something(s) must be done to avoid this disaster! Our suggestion is that we move at a slower pace rather than the "run" being considered at the present time. One viable path to travel is the encouragement of passing local options bills to secure monies to meet local needs.

Senate Bill 62, as sponsored by the Honorable State Senator Walter "Skip" Campbell and House Bill 0229, which is blessed by the prime sponsorship of Representative Susan Goldstein, would enable the votes in each of Florida's 67 Counties to approve funding for services for seniors and the developmentally disabled in their own communities. We urge you to support the concept of ~~these~~ Bills.

Demolishing what has taken a multitude of years to establish is not the direction to pursue. Partnering, with existent and new devotees to the poor, the average income, and all other Floridians, would demonstrate sound business practice, and above all, the promise of living in Florida, for all citizens, in the sunshine of hope, and the promise of dignity.

**TALKING POINTS**  
**LOCAL SERVICES OPTION LEGISLATION**  
**SENATE BILL 62**  
**HOUSE BILL 0229**

Approximately 23% of the State's population is 60 years of age or older. The fastest growing population in Florida is citizens over 80. Currently, there are 841,624 over 80 who reside in the State. High pharmaceutical expenses, illness and/or loss of a spouse, combined with the escalating cost of living, make it difficult for limited income elders to survive in our community. Many people need assistance, especially those who are struggling to care for their frail spouses, and/or themselves.

Keeping frail elders at home is far less costly and definitely more humane than premature nursing home placement, which averages about \$5,000 a month. Waiting lists for in-home services, such as personal care, homemaker, and respite care, are long and perpetually increasing, with middle average income hardest hit by this fact because they do not qualify for Medicaid Waiver Funded Programs, which also have waiting lists. This is a statewide problem.

There is also an increasing number of adults, with developmental disabilities. State funded services for children, in this category, end at 22 years of age. Developmentally disabled persons, over 22, remain in need of intensive services, but often cannot get adequate help.

Approximately 2% of the State's population are developmentally disabled. Their disabilities include: Spinal Bifida; Autism; Cerebral Palsy (CP); Mental Retardation; Praeder-Willi Syndrome; and/or High Risk of Developing a Developmental Disability. Children, and younger adults, up to age 22, are covered by other legislation.

Placing the two vulnerable populations, comprised of elders, 60 and over, along with developmentally disabled adults, 22 and older, within the same legislation, would provide a mechanism that would benefit the multiple needs of both groups.

Approval, by local voters, for supportive dollars, for both Senior and Developmentally Disabled Services, would enable each county to address the needs of local elders, developmentally disabled adults, and their caregivers, through knowledgeable advocates determining the needs and funding services beneficial to both groups.

Monies, raised in each county, would remain in the respective county, They would increase local funds and not replace already existing allocations.

We seek State Legislation, allowing citizens of each county to vote on local option bills to create combined Senior and Developmentally Disabled Service Councils, similar to the Children's Services Councils, already operations, in a number of Florida counties.

# DENTAL MEDICAID COMPARISON OF SERVICES ADI 1<sup>st</sup> QUARTER VS AVERAGE 2003 QUARTER

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ADA SERVICE CODE	PROCEDURE	2003 QUARTERLY AV.	2004 ADI 1 <sup>st</sup> QUARTER	CHANGE
D0120	PERIODIC EXAM	10891	2416	- 78%
D0150	INITIAL EXAM	11517	6310	- 45%
D1120	PROPHY	18977	6628	- 65%
D1203	FLUORIDE	18995	6374	- 66%
D1351	SEALANTS	3654	627	- 83%
D2140	1 SURFACE AMALGAM	2800	2029	- 27%
D2150	2 SURFACE AMALGAM	1975	1808	- 08%
D2160	3 SURFACE AMALGAM	600	525	- 13%
D2161	4 OR MORE AMALGAM	150	139	- 7%
D2330	ANT 1 SURF COMPOSITE	797	358	- 55%
D2331	ANT 2 SURF COMPOSITE	319	180	- 44%
D2332	ANT 3 SURF COMPOSITE	367	187	- 49%
D2335	ANT 4 SURF COMPOSITE	733	318	- 57%
D2391	1 SURF POST COMPOSITE	4174	1247	- 70%
D2392	2 SURF POST COMPOSITE	2540	185	- 93%
D2393	3 SURF POST COMPOSITE	722	107	- 85%
D3220	PULPOTOMY	648	247	- 62%
D3230	PULPECTOMY- ANTERIOR	63	30	- 52%
D3240	PULPECTOMY-POSTERIOR	145	98	- 32%
D7111	EXTRACTION CORONAL REM	487	174	- 64%
D7140	EXTRACTION	2331	633	- 73%

\* Please note changes occurred in ADA coding procedures in middle of 2003 that combined and simplified some codes :

D2140 = D2140 + D2110

D2150 = D2150 + D2120

D2160 = D2160 + D2130

D2161 = D2161 + D2131

D2391 = D2391 + D2380 + D2385

D2392 = D2392 + D2381 + D2386

D2393 = D2393 + D2382 + D2382

D7140 = D7140 + D7110 + D7120



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FOR  
SO. FLA DENTAL ASSOC.

10 D.R. JOHN D. TABAK

TESTIMONY TO MEDICAID REFORM COMMITTEE  
February 14, 2005  
Medicaid Reform Public Hearing

Good afternoon, my name is Stephen Ferrante, I am a Social Worker representing the Broward Older Adult Workgroup, a local coalition of consumers, advocates, providers and a regional chapter of the Florida Coalition of Optimal Mental Health and Aging.

I am grateful for this opportunity to address you today.

Our workgroup understands the financial restraints you face, but better understands the first-hand needs of older adults, persons with disabilities and low incomes.

We believe the solution begins with your hearing today and should be followed with ongoing work and partnership with local communities to define appropriate local service systems and strengthen local community networks.

Local communities and local community providers leverage invaluable, non-traditional and in-kind resources, the type of responsiveness and individualization that some managed care organizations and HMOs do not have a track record of providing.

Last session, you passed Senate Bill 1226. This Legislation creates aging resource centers. We suggest you continue efforts to strengthen and build these local centers and their networks in lieu of implementing the Senior Health Choices.

We believe the solution is not to create yet another structure, pilot, or initiative that further inefficiently disseminates resources.

We believe the Medicaid Modernization Proposal fails to comprehensively analyze and comprehensively respond to the underlying causes of health care cost increases. In addition, it fails to assess the significant general revenues lost by several sales tax exemptions. Here is where we believe lies part of the solution.

Peoples' needs will not go away because of lack of an adequate state budget.

One final suggestion, currently local counties pay a cost of Medicaid nursing home share to the State. It is our understanding that these payments go into a trust fund and not back into aging community-based services that will divert pre-mature nursing home placement. We suggest you redirect these funds back to the local communities.

Thank you.

Senator Carlton, Representative Negrón, and members of the Select Committee, I am Col. Brodes Hartley, the Chief Executive Officer of Community Health of South Dade Inc., a federally qualified health center, (FQHC) serving over forty thousand residents in South-Miami Dade County from Kendall Drive to the Monroe County Line. Including Florida City, Goulds, Homestead, West Perrine and Naranja areas. I also serve as the Chairman of the Board for Health Choice Network, collaboration between 10 Florida community health centers serving approximately 200,000 patients including over 49,000 Medicaid recipients and over 130,000 of our most vulnerable uninsured patients.

I'd also like to recognize several of my colleagues here with me today:

- Rosalyn Frazier, CEO Broward Community Family Health Centers
- Annie Neasman, CEO Economic Opportunity Family Health Centers
- Kathryn Abatte, CEO Miami Beach Community Health Centers
- Alina Perez Stable, Executive Director, Camillus Health Concern
- Andy Behrman, CEO, Florida Association of Community Health Centers
- Margarita Ollet, Vice President of Managed Care and Clinical Operations, Health Choice Network.

FQHCs make up America's safety net for uninsured and underinsured patients with more than 1,000 separate corporations serving over 12 million of America's neediest patients. In Florida, there are 32 of our Community Based Organizations serving over 560,000 patients through 178 access sites. Of these, over 160,000 patients are Medicaid beneficiaries.

As Federally Qualified Health Centers, access sites are conveniently located to patients within their communities, and they are staffed with health care professionals who are proficient in multicultural, multiethnic and linguistic competency skills necessary to provide quality, comprehensive health care services. FQHCs provide comprehensive services to particularly vulnerable populations such as mothers and children, homeless, and HIV positive persons. These services also include dental, behavioral health and some specialty services such as podiatry and optometry.

Health Choice has been actively involved for over 10 years in improving health outcomes and reducing health disparities in a cost efficient manner. Our centers have integrated key finance and IT functions, including a national model for an electronic health and oral health record system. Through our efforts in health information technology, we have been able to focus on key interventions such as faith based outreach prevention programs and disease management programs for chronic diseases including diabetes, asthma, hypertension and behavior health.

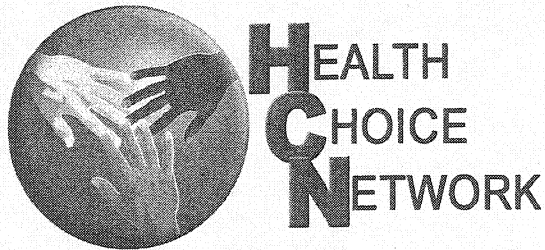
I would like to urge the committee to consider several key issues as you debate the Medicaid health system in Florida:

1. Patients must have access to comprehensive health care services. It would be incorrect to assume that having a Medicaid card implies having access to care.
2. Patients must have a medical home, and not be shuffled from provider to provider.
3. Florida's most vulnerable residents must continue to have access to a strong safety net provider system. FQHC's must be at the heart of any meaningful reform efforts.

4. The program must place an emphasis on health information technology to improve efficiencies and enhance the safety of our health care system.
5. Any reform efforts must include a strong disease management and health compliance program that provides financial incentives for providers showing measurable improvements in health outcomes.
6. We must maintain a long term commitment to prevention and screening activities.
7. The Medicaid program must ensure a strong network of providers that are properly credentialed.

Federally Qualified Health Centers are well positioned to serve as a stable and quality core provider network under Medicaid reform. Because of the national model of our centers, the Florida effort could provide a model for the rest of the country. Health Centers deliver savings to all payers, especially Medicaid. Nationally, health centers have been shown to help reduce Medicaid costs by 30% by providing comprehensive, quality care to our patients.

Thank you for this opportunity to convey a few of our thoughts on Medicaid Reform. We look forward to working with the State of Florida to achieve our mutual goal of protecting and preserving the Medicaid program, employing cost efficiency methods, maximizing structural reforms that will reduce unnecessary paperwork and ensuring that all Medicaid beneficiaries maintain access to quality health care services.



## *Communities that care*

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### CONTACT:

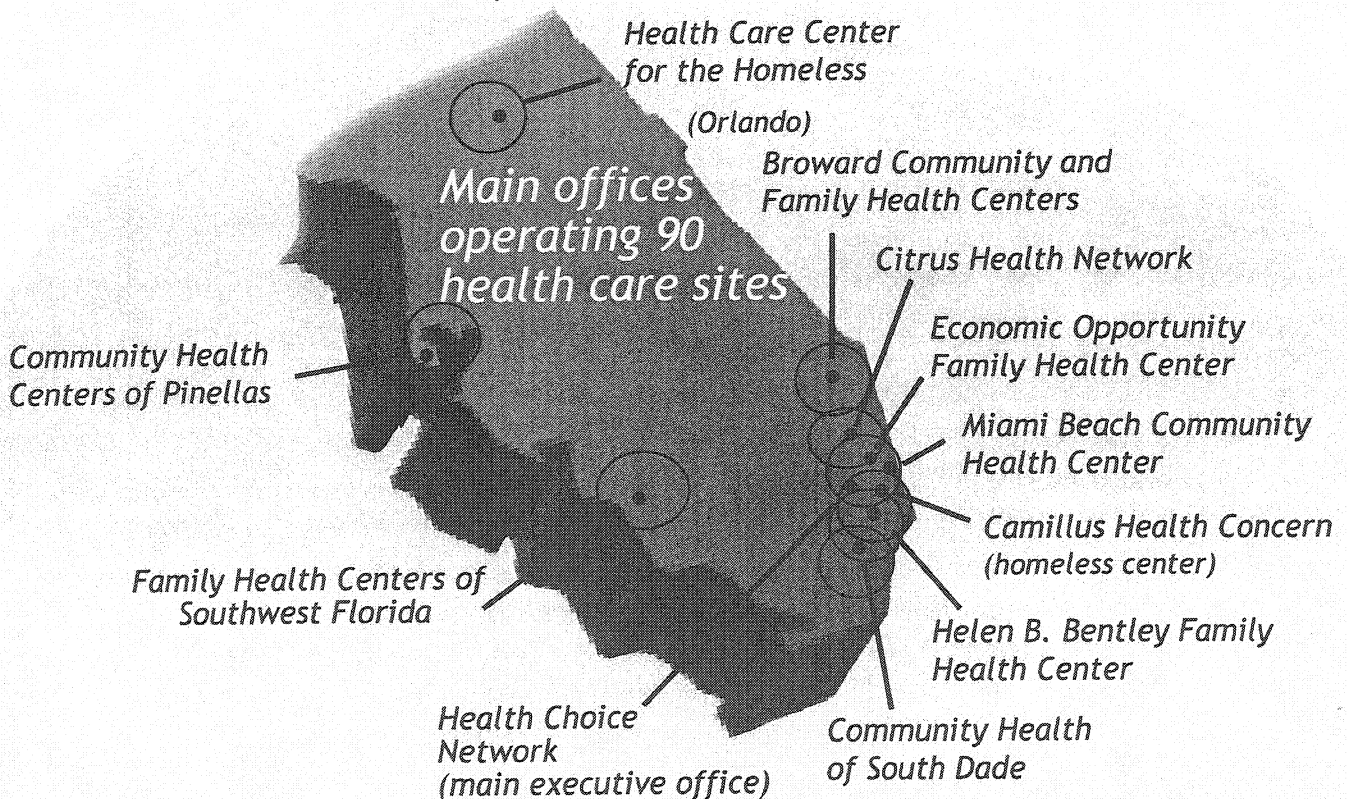
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## Florida counties served by Health Choice Network member centers:

- Miami-Dade
- Broward
- Pinellas
- Lee
- Hendry
- Charlotte
- Seminole
- Osceola
- Orange



## OVERVIEW

Health Choice Network (HCN) is a national model of a successful collaboration between ten Florida community health centers (CHCs) and is a centerpiece of President Bush's REACH Initiative. Through this strong affiliation, HCN is addressing health care disparities, improving health information technologies and strengthening the financial position of the community health care system. Our network of Federally Qualified Health Centers (FQHCs) provides care to nearly 200,000 Floridians in primarily underserved and minority communities. Health Choice Network and its affiliated community-based organizations are uniquely qualified to assist Florida in its efforts to reform our Medicaid system.

Founded in 1994 as a 501c(3) organization, HCN was created and is governed by its members who comprise a minority-based Board of Directors. Network members maintain their vital community orientation by retaining their local-governing, consumer-majority Boards of Directors.

## WHO WE SERVE

Total patients served	195,438	Percent of total
Medicaid patients	49,483	25 %
Uninsured patients	130,362	67 %
Minorities patients served	146,578	75 % (Black 29%, Hispanic 43%)
Homeless patients served	18,048	9 %
Children served	73,306	38 %

## PATIENT SERVICES

Our community health centers are committed to providing high quality, comprehensive health services:

- Family practice
- Pediatrics
- Obstetrics & gynecology
- Pharmacy
- Dental
- Radiology
- Podiatry
- Vision services
- Behavioral health
- Health screening & prevention
- Substance abuse treatment
- Community & patient outreach
- Patient education
- School-based centers
- Disease management
- Extended hours of service
- Care for special populations
  - Migrants & seasonal farmworkers
  - Homeless
  - HIV/AIDS
- Faith-based partnerships
- Healthy Start
- Case management
- Other specialized services

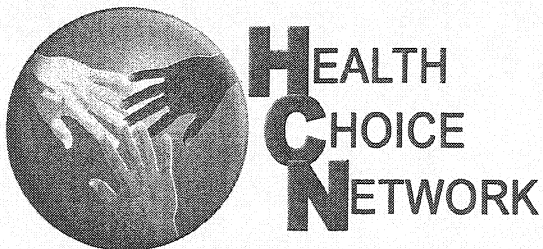
## A PROVIDER NETWORK APPROACH TO MEDICAID REFORM

Federally Qualified Health Centers (FQHCs) have a long history of providing high quality, cost-efficient health care to underserved populations. National studies have shown that every dollar invested in community health centers (CHC) saves Medicaid \$1.14. The restructuring of Medicaid in Florida provides a unique opportunity for our CHCs to play a critical role in the success of the reform efforts. By establishing an FQHC-based community provider network, our CHCs can work collaboratively and directly with the Agency for Health Care Administration (AHCA) to improve outcomes and reduce disparities in a cost-efficient manner. This can be accomplished with a plan that will:

- Ensure commitment to improving quality and health outcomes with a focus on reducing health disparities.
- Provide a stable medical home for Medicaid recipients.
- Guarantee Medicaid recipients access to critical FQHC services provided in a culturally competent environment.
- Promote vital programs such as disease management, faith based outreach, and an emphasis on patient education.
- Promote the use of Health Information Technology (electronic health records).
- Provide necessary fiscal responsibility and budget certainty.

## WHY HCN IS A STRONG PARTNER IN MEDICAID REFORM

- Ten-year track record of reducing health care disparities and improving health outcomes.
- Member centers are the medical home for patients and their families, providing long-term continuity of care.
- Our centers participate in the Health Resources Services Administration (HRSA)-sponsored disease management collaboratives focusing on asthma, cancer, diabetes, cardiovascular health and behavioral health.
- Health Choice Network is certified by Joint Commission on the Accreditation of Health Care Organizations (JCAHO) in Disease Management, with distinction.
- Nearly 150 dental and medical providers are utilizing the Electronic Health and Oral Health Record system (one of six national HRSA-sponsored programs to improve technology).
- Our Network centers are JCAHO-accredited and/or certified by the Bureau for Primary Health Care (BPHC) Primary Care Effectiveness Review.
- Established *Healthy Body, Healthy Soul*, a faith-based outreach and disease management program.
- Network centers are members of the Florida Association of Community Health Centers (FACHC) and the National Association of Community Health Centers (NACHC).
- Developed and operate the Jessie Trice Cancer Prevention Project for member centers.
- Approved as a Fiscal Intermediary Service Organization (FISO) by the State of Florida.
- Health Choice Network is certified by AHCA as a Utilization Review Organization (URO).
- Pending approval as a discount medical plan organization by the Florida Department of Insurance.
- Collaborates with AHCA to operate DiabetikSmart - a diabetes disease management program.
- Our centers operate pharmacies with special pricing based on the Federal 340B drug program.
- Our centers are covered by the Federal Claims Torts Act (FCTA) for malpractice insurance.
- HCN maintains a centralized information technology environment serving all center locations with links to pharmacies, laboratories, local hospitals and the Medicaid eligibility system.
- Coordinates shared risk agreements with partner HMOs to manage the continuum of care for our enrolled patients.
- Our centers participate in Florida SHOTS, a state-wide centralized electronic immunization registry.



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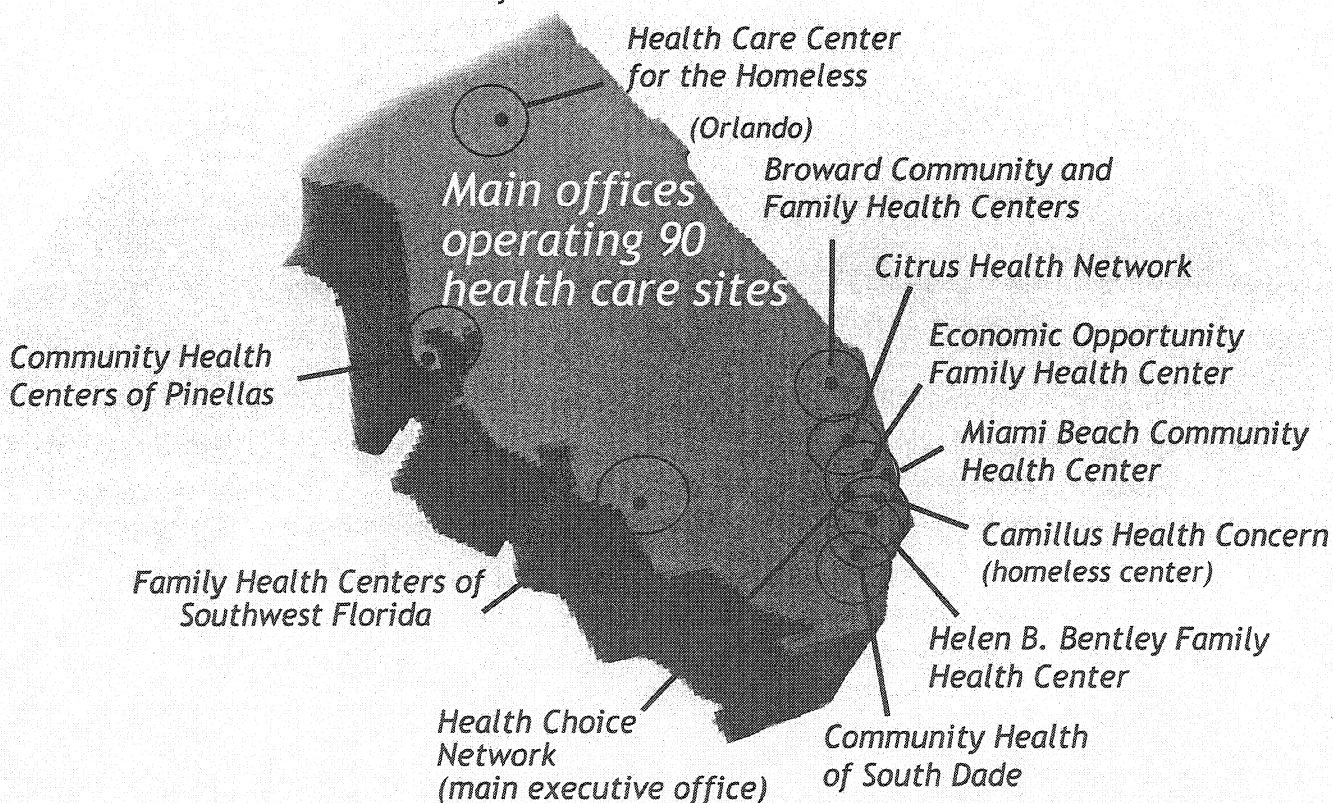
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### Florida counties served by Health Choice Network member centers:

- Miami-Dade
- Broward
- Pinellas
- Lee
- Hendry
- Charlotte
- Seminole
- Osceola
- Orange



**Paul C. Hunt  
Co-Chair  
State Public Affairs Committee  
March of Dimes  
Florida Chapter**

**Medicaid Modernization Proposal**

**Access to health care coverage is central to the March of Dimes mission to improve the health of babies by preventing birth defects and infant mortality.** The National Governor's Association reported that in 2000, Medicaid financed 44 percent of all births in Florida. Nationally, it funds 40 percent of hospitalizations for children born too soon, too small, or with birth defects.

**Medicaid was designed to be a flexible, counter-cyclical program, meaning that it responds to rises in poverty, loss of jobs, loss of private insurance, and other causes of uninsurance.** Currently, the federal government shoulders about 59 percent of the cost of Florida's Medicaid program, with the state picking up the other 41 percent. The governor's Medicaid reform proposal will cap annual Medicaid spending, meaning that Florida can no longer be flexible to need arising from unforeseen events, such as hurricanes and tornadoes. If Florida's Medicaid spending is fixed, as in the current modernization proposal, the state would receive a low amount of funding per recipient, making it difficult or impossible to cover a host of badly needed services for pregnant women, infants, and children.

**Without the guarantee of coverage, many of Florida's pregnant women and children will lose access to needed health care services.** Uninsurance rates will inevitably rise, exposing the health of pregnant women, infants, and children to higher risk.

- **Prenatal care is crucial to identifying problems early and providing treatment that may help improve the health of both the mother and baby.** Twenty-nine percent of uninsured pregnant women have no usual source of care, while 15 percent will have no prenatal visits at all.<sup>1</sup>
- **Children who lack health care coverage tend to receive care late in the development of a health condition, if they even receive care at all.** This places an enormous burden on hospitals, who are likely to see these children in an emergency room for treatment of a condition that could have been contained with timely outpatient care.<sup>2</sup>
- **Uninsured children with special health care needs suffer the most.** They are more likely than insured children to be without a usual source of care. Most likely, they will have gone at least 12 months without seeing a doctor, and are more likely to find medical, dental, vision, and mental health care, as well as prescription drugs, out of reach.

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<sup>1</sup> Bernstein, Amy B. 1999. *Insurance Status and the Use of Health Services by Pregnant Women*. Washington DC: March of Dimes.

<sup>2</sup> *Health Insurance is a Family Matter*. 2002. Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine of the National Academies. Washington DC: National Academies Press.

**The modernization proposal does not offer any guarantee that pregnant women, infants, and children with special health care needs will have access to services they need.** Under the governor's proposal, insurance providers – not federal law – will dictate the amount, scope, and duration of services available to pregnant women and children. Further, the proposal offers no safeguards against "cherry-picking," where individual market insurers can choose to cover only those patients who are relatively healthy. Sick children, or high-risk pregnant women, will undoubtedly have a hard time finding quality affordable health coverage.

- **Pregnant women may encounter difficulty finding affordable, comprehensive health care with maternity benefits.** The modernization proposal amounts to a health care "voucher" with which patients can purchase private health insurance. Unfortunately for pregnant women, health care services related to pregnancy and childbirth are typically absent from health insurance policies sold in the individual market. Where it is available, it is very expensive and quite limited. Coverage for women who are already pregnant (which would be all women in Medicaid who become eligible solely because of their pregnancy status) is simply not available at any price. Even state high-risk pools usually consider pregnancy a pre-existing condition and exclude maternity care from coverage.<sup>3</sup> Any Medicaid reform plan must guarantee that pregnant women will be able to access prenatal and maternity care.
- **Children with birth defects and other special health care needs could be left without access to the care they need.** Under federal law, every child identified as having a health care condition through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is guaranteed all medically necessary treatment services for that condition, regardless of whether or not the state Medicaid plan covers those services for other populations. This benefit is a lifeline for the sickest children in Medicaid, who would likely have difficulty finding affordable individual market plans that offer such comprehensive screening, diagnostic, and treatment services. Even the catastrophic coverage allowance in the proposal comes with a limit. At what point would a truly sick child exhaust their maximum benefit allowance, and what is to become of them if they reach this point? The most vulnerable may lose their right to all medically necessary services.

March of Dimes  
Florida Chapter

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March of Dimes, Florida Chapter  
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<sup>3</sup> Neuschler, Ed, Institute for Health Policy Solutions. 2004. *Policy Brief on Tax Credits for the Uninsured and Maternity Care*. Prepared for the March of Dimes.

**Florida Pediatric Society  
Florida Chapter of the American Academy of Pediatrics  
Comments Regarding the Governor's Proposal to Change Medicaid**

I speak today on behalf of the Florida Pediatric Society in the capacity of president elect of the chapter.

The goal of the society is to advocate for each and every child in our state and assure that all children have the same benefits of the great medical care we have in the United States. The emphasis is on equal care, no matter what the income level. For many years Medicaid has been the source and resource for children in the poorest of families and the number of these children continues to grow each year. It is not necessary to reiterate the fact that most of these children would have no care at all if not for the Medicaid system and that every system has it's flaws.

The system itself puts down roadblocks which denies adequate access to health care services. Problems such as lack of continuous eligibility, physician changes without the parents knowledge and lack of transportation options for these parents when they cannot access the care that is needed, is only a few of the issues.

Unfortunately, with the increase in paper work and decrease or lack of increase in reimbursement and lets not forget punitive physician audits, many physicians in the state will no longer accept these patients. The increase in payments that have been given over the years, have only been in small increments, far from the increase in cost of maintaining a practice, yet the ability to get needed services for the children and time needed to obtain that care, only worsens. The State is looking to cut funds for this program, which could mean even less services for the children of our state and less payments to physicians, which only constitutes 4% of Medicaid expenditures

We, the pediatricians of the State of Florida, are concerned that the Governor's proposal will only mire down an already cumbersome and poorly funded program. We have four major concerns with the movement to reform Medicaid.

1. **EPSDT**: The American Academy of Pediatrics has developed an universally accepted standard

for child health care in this country. This includes a schedule for health care screening, developmental screening and routine vaccinations. In Florida this is supported by the Florida Statutes 627.6579 and 641.31(30)(b), known as the Child Health Assurance Act. This requires all commercial health plans to provide the above services for all children it insures in the state. Under Medicaid, these same services are known as EPSDT (Early Periodic Screening Diagnosis and Treatment), now called Child Health Checkup. These services are mandated by the Federal Government under Title XIX of the Social Security Act, however, they are not truly addressed in the Governor's new proposal. Each and every child deserves the same level of care in our state and to not include the EPSDT package in the renovation of the Medicaid program would be a crime against our future generations.

2. **CMS:** We are unclear where Children's Medical Services, (CMS), Florida's premiere program for children with special health care needs, fits into the Governor's proposal. CMS is a complex program with an ever-changing patient population. CMS depends on fee-for-service Medicaid funding which seems to disappear under the new recommendations. We realize that this is not the intention, but this proposal could jeopardize a nationally recognized model which demonstrates the benefits of a public-private partnership to provide both a medical home and specialty services to Florida's children with special health care needs and other indigent children. We strongly encourage that you safeguard this very essential program.

3. **Co-payments:** The Governor's proposal speaks to allowing participants to "...contribute to the cost of their care...". This suggests the institution of a co-payment which is forbidden for children under the Federal Medicaid Statute. Additionally, cost sharing could potentially reduce the use of necessary services, leading to a potential increase in the use of emergency services, increase the severity of the illnesses and exponentially increase the cost of care. This approach will simply shift the cost from the current federal-state shared responsibility, to the private sector. The private sector is already insufficiently compensated for the services rendered to Medicaid recipients, and such action will stress an already small list of generalists and sub-specialists who at this time continue to accept the program. Please strongly consider this when revamping of the

program. We need to increase our physician rosters not drive away the providers we already have.

4. **Managed Care:** Managed care organizations have one bottom line, that is to increase the profits for their shareholders. This will severely limit the dollars spent on health care and as usually occurs in an HMO system, reward physicians for not seeing the patients. This will only decrease the services given to an already underserved population. In this time of budget short fall, it is incomprehensible that Florida would propose to cap the available per-patient dollars, impose more managed care, and thereby further limit the services available to any individual patient. It has already been shown in the past the care for the Medicaid children is cheaper under MediPass (or fee-for-service), than it is under the Medicaid HMO's and has a much wider participation by physicians around the state. The *Florida Medical Business* journal recently reported that in the MediPass program "...3,002 providers rendered care to more than 702,00 beneficiaries last year..."

In summary, shifting of the Medicaid program into an HMO system could be quite detrimental to the health and well being of the children of Florida. The Florida Pediatric Society has grave concerns that the plan will already aggravate and perpetuate the problems that exist. There are other alternatives available to improve the system and these programs must be sought in order to improve not destroy the health of our children.

Respectfully Submitted:

David Marcus, MD  
President Elect , Florida Pediatric Society

# **JOINT PUBLIC HEARINGS ON MEDICAID REFORM**

**February 14, 2005, Ft. Lauderdale, Fl.**

**Dee Mason  
20918 Blacksmith Forge  
Estero, Fl 33928  
Hm. Phone:239-495-2022  
Email:msdm@swfla.rr.com**

**Profile: Retired from a major airline after thirty-one years of overseas service to care for my mother who is suffering from Alzheimers disease. My mother is currently residing at Shady Rest Care Pavilion Inc., a Not-For-Profit Skilled & Rehab Facility located in Ft. Myers, Fl. My father-in-law also resides at Shady Rest . My father is blind and I am his constant companion visiting my mother and father-in-law daily.**

**Representing: Family Members of "Family Council", a membership program designed for family members of residents of Shady Rest, and "Family Forum". The following members are registered voters of Lee County; George DeGrout; Mary Lou Stinson; Thelma Morocco; Emily Alvarez; Ann Gomez; Joyce Tennison; Lowell Mason; Tom Carrigan; Michael R. Schultz; Betty Germann; Betty Kreiber; Bob Maloney; and Amelia McCreary.**

## **Topic: Senior Health Choices-Long Term Care**

**We are aware that about 28% of the Medicaid Budget will be spent on longterm care reimbursements. We know this figure, unless changes occur, will be an enormous burden to the state, especially when baby boomers become of age. But, we also know that additional administration costs will have to be added to pay for the program. Who will assume these costs? Nursing homes are already fighting budgets with Medicaid reimbursements being cut back ( 2.5% in July and 2.5% again in January). I represent a group of people who spend everyday, two to three hours a day, visiting and assisting our love ones with their daily needs along with visiting other residents and helping as volunteers where we can. That ladies and gentlemen adds up to over twenty-eight to forty-two hours a day! Not too many groups understand better the everyday challengers of the "nursing home community". We live it! It's hard work! We fear these costs, if they fall on the burden of the nursing facility, will alter the quality of life for our love ones.**

**Who will determine the criteria in which a nursing facility must meet to qualify for participation in the managed care program? We fear that too many departments are to be involved. Who will be accountable? Who determines the definition of “chronically poor performing nursing homes”?**

**If the minimum time for implementation is twelve months what is the maximum time? If the new program doesn’t work how soon before we revert back to the traditional Medicaid Program or is there an alternative plan.**

**In closing, Florida has the highest nursing home mandatory staffing requirements in the U.S. To coin a phrase “we have come a long way baby”. We have overcome the stigma of the nursing home. Let us be careful not to jeopardize that integrity!**

**I live in one of the fastest growing counties in the state with homes selling in the upper one hundred thousands. Representing some of the wealthiest populations in the U.S.! These people are financially capable of paying thousands of dollars to attorneys to find Florida’s loop holes in our legal system and qualify for our Medicaid Programs. Perhaps it is time to take a look at those loop holes. And close them!**

**I don’t know what the answer is. There is no magic! I believe that we must protect and treasure our seniors.**

**“Ordinary People Can Make Extraordinary Differences”**

**Thank you so much for your time and the opportunity to speak to this esteemed committee.**

**Dee Mason-Family Advocate**

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## **SILENT CRISIS IN THE U.S.**

### **TO THE CAREGIVERS OF PERSONS WITH UNTREATED, SEVERE MENTAL ILLNESS.**

"Yours may be the one out of every five families in the United States that is or will be directly affected by a serious brain disorder" ("Open Your Mind", NAMI, 1997.)

The following information, copied from the Miami-Dade County Grand Jury Final Report, the United Nations and the World Health Organization (WHO), is sent to you with the explicit intent to awaken the conscience of the general public and to compare how the U.S. and the rest of the world address the care of persons with severe mental illnesses who lack insight and/or have substance abuse problems.

Since the affected persons are unlikely to ask for help, we strongly urge there be a formation of a panel of non-experts, to impartially and objectively evaluate and bring to light the economical and emotional cost to the community caused by the lack of appropriate care to our relatives and, after deliberations, to recommend to our legislators the changes in the law and funding needed to improve services.

The panel could include: family members of "Difficult to Treat Mentally Ill Persons," mentally ill individuals in recovery, police officers, members of civic and religious organizations such as the Chambers of Commerce, real estate agents, neighborhood groups, county officials, etc. Those who should not participate on the panel would include: providers of mental health, judiciary or correctional services, health insurance or pharmaceutical representatives, researchers, professors and intellectual experts in mental health, etc.

After deliberations, the panel would be able to recommend to the Legislature the changes in the law and funding needed to remedy this inequity. Is there in the U.S. an impartial civic-minded person or group, who would be able to organize such a panel?

The mentally ill population, their families, the community and the legislators would all benefit from a different perspective - one that would have the potential to improve the quality of life for all of us.

Sincerely,

Families of Untreated Mentally Ill Persons

[www.lackofinsightmi.org](http://www.lackofinsightmi.org)

P.O. Box 83-2816

Miami, FL 33283-2816

Phone: 305-274-3076

Fax: 304-273-0261

February, 2005.

**In the best interest of all Americans, please consider:**

**The Miami Dade County Grand Jury Final Report - Spring Term A.D. - 2004, underlines, (page 2) "there are three times as many men and women with mental illnesses in U.S. prison as in state psychiatric hospitals", and (page 17): "During the year 2000, taxpayers in King County (Seattle) Washington spent over \$1.1 million on drug and alcohol acute services and criminal justice resources for just 20 individuals. Similarly, in Summit County (Akron Ohio, during the year 2001, the cost to taxpayers for a group of 20 individuals was \$1.3 millions.**

**The UNITED NATIONS's Standard Minimum Rules for the Treatment of Prisoners Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977, establishes:**

**"B. INSANE AND MENTALLY ABNORMAL PRISONERS**

**82. (1) Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.**

**(2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.**

**(3) During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.**

**(4) The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.**

**83. It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric after-care."**

**[See complete Report: <http://shr.aaas.org/thesaurus/instrument.php?insid=124>**

**The World Health Organizations (WHO) recognizes the burden to the families and to the community "especially when the health system is unable to offer treatment and support at an early stage."**

**"THE BURDEN OF THE FAMILIES**

**Fact sheet N°218**

**Revised November 2001.**

**Mental illnesses affect the functioning and thinking processes of the individual, greatly diminishing his or her social role and productivity in the community. In addition, because mental illnesses are disabling and last for many years, they take a tremendous toll on the emotional and socio-economic capabilities of relatives who care for the patient, especially when the health system is unable to offer treatment and support at an early stage. Some of the specific economic and social costs include:**

- lost production from premature deaths caused by suicide (generally equivalent to, and in some countries greater, than deaths from road traffic accidents);
- lost production from people with mental illness who are unable to work, in the short, medium or long term;
- lost productivity from family members caring for the mentally-ill person;
- reduced productivity from people being ill while at work;
- cost of accidents by people who are psychologically disturbed, especially dangerous in people like train drivers, airline pilots, factory workers;
- supporting dependents of the mentally ill person;
- direct and indirect financial costs for families caring for the mentally-ill person;
- unemployment, alienation, and crime in young people whose childhood problems, e.g.,
- poor cognitive development in the children of mentally ill parents, and the
- emotional burden and diminished quality of life for family members."

Other sites of interest:

<http://www.psychlaws.org/JoinUs/founding.htm>

<http://www.miami.com/mld/miamiherald/news/editorial/letters/10592153.htm>

*Arlene Lakin, Esq.*  
*Attorney at Law*



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February 2005

Dear Clients, Colleagues & Friends:

There is some pending legislation in Tallahassee that is very bad, and some that is very good.

I am sending you information regarding three bills which are of great interest to persons who care about the elderly and persons with developmental disabilities.

Please get involved and help contact legislators.

WHAT CAN YOU DO TO HELP?

1/ Please contact your state representative and state senator ASAP -

- a phone call to their local district office;
- a letter;
- an e-mail

NOTE: To find out who are your 2 legislators, look on the back of your voter's registration card where you will find your district numbers. You can then go to the white pages of the phone book and match your district numbers w/ your legislator.....or.....go to the internet (Florida Legislature: [www.leg.state.fl.us](http://www.leg.state.fl.us)) Legislator's contact information is in the phone book and on the internet.

2/ Encourage neighbors, co-workers, family members, friends to help get the word out about this legislation.

3/ Contact Rep. Don Brown regarding his HB 543 & let him know you oppose it:

Rep. Don Brown, OWCC Bldg 2, # 205, 908 Hwy. 90 West, Defuniak Springs, FL 32433  
Telephone 850/892-8431

This is statewide legislation and will affect families throughout Florida. Every voice counts - please do not rely on others to be your Voice! Thank you so much for helping!

Sincerely,

*Arlene Lakin*  
Arlene Lakin, Esq.

**OPPOSE HOUSE BILL 543** - Proposed by Rep. Donald Brown (DeFuniak Springs, Fla.)

HB 543 makes it nearly impossible for anybody to get onto Medicaid for nursing home coverage:

- requires 6 year look-backs for transfers (currently, 3 year look-backs; 5 years if to/from a trust);
- penalty time periods that normally run out before you apply will not start to run until the moment you apply (if you're applying within the 6 year look back)
- transfers of home to eligible persons under federal law won't apply anymore  
Ex: After 2 years a parent who has lived with their adult child could not transfer home to adult child (currently permitted);  
Ex: A parent could not transfer their home to a disabled adult child (currently permitted)
- transfers between spouses are severely limited once one spouse is on Medicaid
- personal service contracts: can't duplicate anything otherwise provided by Medicaid & must be medically justifiable & must be a notarized agreement
- annuities for Medicaid must use SSI life expectancy table BUT now if the annuitant is really sick, a physician's statement of a shorter life expectancy will be required.  
APPLIES TO:
  - private annuity;
  - annuities that don't pay out equal payments monthly (income & principal): forget small payments with large balloon at the end of one's life per actuary tables

EFFECTIVE DATE (if passed): July 1, 2005

Exception to effective date: Any language that conflicts with federal law will not take effect until (a) federal law is changed; or; (b) when state obtains a federal waiver [AHCA will be required to apply for such a waiver if, by 10/1/05, federal law is unchanged; such waiver application must be filed by 1/1/06]

\*\*\*\*\*

**SUPPORT HB 229**/Rep. Susan Goldstein (SB 62/Senators Rich & Lynn) -

This legislation would allow counties to create, by ordinance, independent special districts to provide services for seniors and adults with developmental disabilities.

\*\*\*\*\*

**OPPOSE HB 107**/Rep. Carlos Lopez-Cantera (SB 618/Senator Rudy Garcia) -

Currently a small group home provider (6 beds or less) can open a group home without zoning variances (& neighbor's OK) as long as home is at least 1,000' from nearest group home. HB 107 would revoke this "1,000' rule" and make it nearly impossible for group homes, esp. for persons with developmental disabilities, to open in regular neighborhoods.



Florida Association of  
Healthy Start Coalitions

## Medicaid Reform What is the Right Prescription for Florida?

Medicaid is a joint federal-state program that provides health care coverage for 2.1 million Floridians. In FY 2004, the Medicaid budget exceeded \$11 billion. Concerned with program growth, policymakers plan to seek a federal waiver that would give the state more flexibility in implementation in exchange for limits on future federal funding.

### Summary Statements:

Evaluation of Medicaid's current program funding, coverage and services—and the potential impact of reform efforts on pregnant women and children—led the Florida Association of Healthy Start Coalitions to adopt these principles:

1. "Baby Steps" should be taken in Florida's Medicaid reform process. A thoughtful, systematic review process is necessary. Comprehensive consideration of the issues, careful planning and broad citizen and provider input are critical to the development of sound solutions. To this end, the Association supports the establishment of a statewide Medicaid Reform Commission, to craft a comprehensive package of program reforms.
2. Targeted cost containment strategies will be more effective than across-the-board cuts or caps on eligibility, provider fees or services.
3. Medicaid reforms should maximize dollars available for health care. Third party administrative costs reduce enrollee benefits and provider payments.
4. Medicaid reforms should balance cuts with increased investment in primary and preventive health care for Florida's most vulnerable families. Preventive and primary health care is less expensive and reduces the need for costly chronic, acute and long-term care services. Increased support for preventive and primary care, particularly for those who do not currently have access to this care, represents Florida's most significant opportunity for controlling Medicaid costs in the future.

### Overview

Medicaid is a joint federal-state program that provides funding for vulnerable populations, including pregnant women, children, the disabled and low-income elderly. Florida's Medicaid program currently covers more than 2.1 million residents. Children make up more than half of the Medicaid enrollees. The program pays for nearly half of all births in the state by providing expanded benefits to uninsured pregnant women. Florida also provides optional benefits that expand coverage for family planning services and Healthy Start case management services. Medicaid program costs exceeded \$11 billion in FY 2004, including \$6.7 billion in federal funding and \$4.6 billion in state funding. It is the single largest source of federal funds coming into the state.

Concerned with the growth in the state's share of Medicaid costs, the state plans to seek a federal waiver that would provide the state with more flexibility in program design and funding. In return, federal support to the state would be capped based on anticipated expenditures and savings.

Proponents of reform cite the following as rationale for a massive overhaul:

- The Medicaid program has not changed significantly since its inception in 1965, despite enormous changes in health care.
- The current program is too costly and consumes too much of the state's budget.
- The current program does not allow sufficient flexibility to meet the needs of those it was designed to serve.

This paper explores issues related to Florida's Medicaid reform efforts and proposes cost-control principles that balance fiscal concerns with the health care needs of the state's neediest residents.

### **Medicaid Expenditures and Cost-Effectiveness**

While Medicaid represents a large proportion of the state budget, Florida spends significantly less per person than the national average (\$4,679 vs. \$5,985 in 2002). In fact, the state ranks 41<sup>st</sup> among states in per enrollees spending. Additionally, Medicaid costs have increased at a slower pace than private insurance costs over the past few years.<sup>1</sup>

The United States is struggling with health care costs. The problem is not limited to the poor. In fact, health care in the source of financial crises for middle class Americans, contributing to half of all personal bankruptcies in 1999.<sup>2</sup>

Proponents of massive overhauls of Florida's Medicaid program claim expenditures are "too costly." In fact, Florida's system is quite cost effective, even when compared to private insurance products. Medicaid recipients tend to be older and sicker than those enrolled in private health care insurance programs. One would expect the costs to be higher under these circumstances. However, when adjusted for increases in enrollment, Medicaid costs on a per capita basis have risen at a slower rate than private insurance products in Florida. *In 2003, private insurance cost nationally increased by just under 14 percent, while Florida's Medicaid per capita cost increase was just under five percent.*<sup>3</sup> Children covered under Medicaid are significantly less costly than those covered in the private sector even when children with disabilities are included.<sup>4</sup> The track record of private insurers and managed care organizations in containing costs should be considered before involving them in Medicaid reform efforts. Administrative costs incurred by these organizations further reduce Medicaid dollars available to meet the health care needs of enrollees.

The Medicaid program provides an important and cost-effective source of funding care for uninsured Floridians. Nearly 1 in 5 residents under age 65 is uninsured. Medicaid covers about 14% of all Floridians. The state provides this coverage with significant assistance from the federal government. For every state dollar spent on the Medicaid program, Florida receives \$1.44 in federal funding.

Cuts in state funding will reduce the availability of federal support for the program. Reductions in state Medicaid expenditures, however, will not reduce health care costs. Since the need for care remains, the *full cost* of care will be shifted to local government, hospitals, doctors and the privately-insured.<sup>5,6,7</sup> For many covered groups, including uninsured pregnant women, benefit cuts are likely to reduce access to prenatal care and other services, resulting in increased state costs as their risks for poor birth outcomes increase. An increase in low or very low birthweight babies will result in an increased population *dependent on Medicaid* for lifelong medical care and related services.<sup>8</sup>

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<sup>1</sup> Florida's Medicaid Budget: Why are Costs Going Up? Policy Brief, July 2004. Winter Park Health Foundation.

<sup>2</sup> Reframing the National Health Care Discussion. Position Paper, Brian Klepper and Jeannette Corbett

<sup>3</sup> Hadley, J, Holahan K. "Is Health Care Spending Higher under Medicaid or Private Insurance?" Inquiry Winter 2003-2004 (40); 323:342 as quoted in Florida's Medicaid Budget: Why are Costs Going Up? Policy Brief, Winter Park Health Foundation, July 2004.

<sup>4</sup> Florida's Medicaid Budget: Why are Costs Going Up? Policy Brief, Winter Park Health Foundation, July 2004.

<sup>5</sup> Ellen O'Brien and Cindy Mann. Maintaining the Gains: The Importance of Preserving Coverage in Medicaid and SCHIP. Georgetown University. June 2003.

<sup>6</sup> Joan Alker and Lisa Portelli. *What Could A Waiver to Restructure Medicaid Mean for Florida?* Winter Park Health Foundation, April 2004.

<sup>7</sup> Joan Alker, Georgetown University Health Policy Institute. Presentation at Medicaid Reform Symposium: The Future of Florida Medicaid, July 12, 2004, Orlando.

<sup>8</sup> Cut Costs--Not Prenatal Care. The Lawton & Rhea Chiles Center for Healthy Mothers & Babies, 2004.

### **Medicaid Coverage and Impact on Costs**

While children constitute the largest group of Medicaid eligibles, they account for the smallest proportion (<30%) of costs. Expenditures associated with pregnancy are less than 5% of the Medicaid budget.<sup>9</sup> Nearly three-quarters (70%) of program costs are attributable to services for the elderly and people with disabilities.<sup>10</sup> Similarly, the bulk of Medicaid expenditures are for acute, chronic and long-term—rather than primary and preventive—services. Prescription drugs, nursing home care and inpatient hospital services account for more than 45% of all program costs.<sup>11</sup>

When it was enacted in 1965, Medicaid was primarily intended to serve women and children, creating a safety net for poor and vulnerable families. Shifts in demographics, changes in the health care system and increases in health care costs, however, produced pressure on states to use the program to address gaps in coverage, particularly for the elderly covered by Medicare. This situation has a particular impact in Florida where the number of seniors, who currently make up 17% of the population, is significant and growing.

Increases in Medicaid enrollment and utilization are cyclical. History shows that when Florida's economy and tax revenues slow, more people qualify for coverage.<sup>12</sup> Additionally, recently enacted federal reforms, including new prescription drug coverage under Medicare, are likely to have a favorable impact on the costliest component of the state program.

Under Medicaid guidelines, states are required to cover certain groups and may choose to cover additional groups. The same is true of services. About 41% of the Florida Medicaid budget is spent on mandatory categories, while 59% is spent on optional groups and services.<sup>13</sup> Among the services and groups considered optional are prescription drugs and expanded coverage for pregnant women and uninsured children. Florida chose to meet the need for these services through Medicaid due in large part to the federal match associated with the program.

Under any federal waiver, the state will be prohibited from reducing coverage for mandatory groups. Instead, cuts will focus on program administration, optional categories, services, or provider reimbursement.

### **Reforming Medicaid: Unanticipated Consequences**

Changes to Medicaid can produce significant unintended impacts. For example, changes to eligibility for pregnant women may result in high health care costs for their newborn infants born too soon or with adverse conditions due to inadequate pre-natal care of the mother. Incorrect estimates of expenditures can lead to deficits. Should projected expenditure estimates made by the state in negotiating a federal waiver be incorrect, even by a single percentage point, Florida would be responsible for any additional costs above the agreed-upon cap.<sup>14</sup>

In fact, a process already exists in which changes to Medicaid are made that accomplish the goals of customizing the program for patient needs, improving cost effectiveness, reducing bureaucracy and promoting innovations. Florida has utilized this process to create 13 “waiver” programs. Medicaid waivers allow the State to propose needed program changes through the federal Center for Medicaid and Medicare Services (CMMS).

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<sup>9</sup> Ibid.

<sup>10</sup> A Snapshot of Florida Medicaid. Florida Agency for Healthcare Administration, November 30, 2004.

<sup>11</sup> Ibid.

<sup>12</sup> Joan Alker and Lisa Portelli. *Florida's Medicaid Program: Why Costs are Going Up*. Winter Park Health Foundation, July 2004.

<sup>13</sup> Florida Medicaid: A Case for Modernization. Florida Agency for Health Care Administration, Presentation by Thomas Arnold, Deputy Director for Medicaid, November 4, 2004.

<sup>14</sup> Joan Alker. Presentation “Florida's Medicaid Program: What Could a Waiver Mean?” August 11, 2004.

Thoughtful, incremental changes to the system have been made to Medicaid, although constant improvement is always needed.

### **The Reform Process**

Floridians have expressed their concern over broad, sweeping changes to the Health Care system including Medicaid. A recent survey by Mason-Dixon Polling & Research found:

- When compared with other responsibilities, including education, environment, law enforcement and economic development, more Floridians indicated health care was the most important function of Florida state government. 63% of Florida voters named health care as one of the top three most important functions of state government—28% said it was “the most important function.”
- When asked specifically about Medicaid, 82% of Florida voters feel it is important for Florida state government to provide health care coverage to uninsured children and uninsured low-income working adults, with 58% feeling it is “very important.”
- When advised that Florida’s Medicaid program accounts for one quarter of the state budget and knowing that will increase due to population growth among those who qualify, 73% of Florida voters still feel that the state of Florida has a “responsibility to assist in providing health coverage for uninsured children and uninsured working low-income families.”
- Only 33% of Florida voters are aware that Florida is considering changes to its Medicaid program.<sup>15</sup>

Members of Congress have also been critical of attempts to use the Waiver process to make fundamental changes to the financing of Medicaid that circumvent the basic tenets of the program.

Changes to Medicaid must not be reckless or effected without broad public input. They must not endanger the health of patients and must not place the citizens of Florida at risk of absorbing higher health care costs through shifting care to other parts of the health care system. Reforms to the Medicaid program, which provides the only source of health care for 1 in 5 Floridians under age 65 should be the result of an open and inclusive public policy discussion.

### **Proposed Principles for Reforming Medicaid**

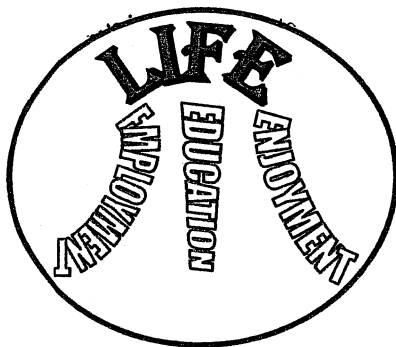
Based on these considerations, the Florida Association of Healthy Start Coalitions supports the following principles for Medicaid reform:

1. “Baby Steps” should be taken in Florida’s Medicaid reform process. A thoughtful, systematic review process is necessary. Comprehensive consideration of the issues, careful planning and broad citizen and provider input are critical to the development of sound solutions. To this end, the Association supports the establishment of a statewide Medicaid Reform Commission, appointed by the Legislature, to craft a comprehensive package of program reforms.
2. Medicaid reforms should focus on the costliest users and services. Targeted cost containment strategies will be more effective than across-the-board cuts or caps on eligibility, provider fees or services.
3. Medicaid reforms should maximize dollars available for health care. Third party administrative costs reduce enrollee benefits and provider payments.
4. Medicaid reforms should balance cuts with increased investment in primary and preventive health care for Florida’s most vulnerable families. Preventive and primary health care is less expensive and reduces the need for costly chronic, acute and long-term care services. Increased support for preventive and primary care, particularly for those who do not currently have access to this care, represents Florida’s most significant opportunity for controlling Medicaid costs in the future.

ADOPTED January 28, 2005

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<sup>15</sup> Florida Health/Medicaid Survey. Mason-Dixon Polling & Research, Inc. December, 2004.



## **Living Inclusively For Everyone, Inc.**

**350 N.W. 84<sup>th</sup> Avenue, Suite 211**

**Plantation, FL 33324**

**954.817.4742**

**954.236.5071(FAX)**

To: Committee Members

From: Laura Prado

Date: February 14, 2005

Re: Proposed Medicaid Reform

I come here today wearing many hats. I come as the mother of a 14 year old with autism who is a consumer of Medicaid services. I come as a founding member of Living Inclusively For Everyone a grass-roots organization committed to the inclusion of persons with developmental disabilities into their community. I come as a taxpayer and as someone who works in the health provider field. As such, I have first hand knowledge of the Medicaid problem from many angles.

I agree with Governor Bush that something must be done to curtail the skyrocketing increases in Medicaid but we must ask ourselves at whose expense. Currently according to the Florida Agency for Health Care Administration over 70 percent of Medicaid costs pay for care for people age 65 and over and the disabled. Healthcare costs are rising everywhere and yet we seem only to focus on the most vulnerable in our society when we talk of cost containment.

The proposed Medicaid reforms seem nothing more than a shell game to me. The proposed reforms call for caps. Yet caps don't eliminate the need for health care services they merely shift who pays for the required services. Under the proposed reforms hospitals and counties will bear the burden of providing services for any Medicaid recipient who has maxed out on benefits. The cost of the services provided does not disappear because the individual's coverage has been maxed out.

The proposed Medicaid reforms not only set caps on coverage but also by adding more layers of bureaucracy will actually add more administrative costs than currently in the system. The reforms envision private HMO provider networks. Let's not forget the fiasco Florida has seen with fly-by-night providers skimming off profits and then folding up leaving all of us to cover the costs and clean up the mess.

David M. Steiman, M.D., President  
Stanley Hinden, Vice-President

Robert Wessels, Treasurer  
Laura B. Prado, Secretary

Is there a solution? Yes there is but we need to go to the root of the problem. Why is there an ever expanding pool of people in our wonderful country who don't have private health insurance? Why doesn't the Governor and/or the Legislators require all businesses that hire 10 or more employees to provide health insurance coverage? Why don't we require our school systems to establish employment-based educational programs for students with disabilities? These would be positive and real ways to reduce the Medicaid budget.

in the Texas public mental health sector.<sup>9</sup> The target population for TMAP is persons with serious and chronic mental illness who are served by public programs.

The goals of TMAP are twofold: 1) to improve the quality of care and achieve the best possible patient outcomes for the resources expended; and 2) to develop and continuously update treatment algorithms and use them to reduce the immediate and long-term emotional, physical and financial burdens of mental disorders for clients, their families, and their health care systems.<sup>10</sup> The components of TMAP include:

- 1) Evidence-based, consensually agreed upon medication treatment algorithms,
- 2) Clinical and technical support necessary to allow clinicians to implement the algorithms,
- 3) Patient and family education programs (which describe the nature of the illness and the effects of various medications) that allow the patient to be an active partner in care, and
- 4) Uniform documentation of care provided and resulting patient outcomes.

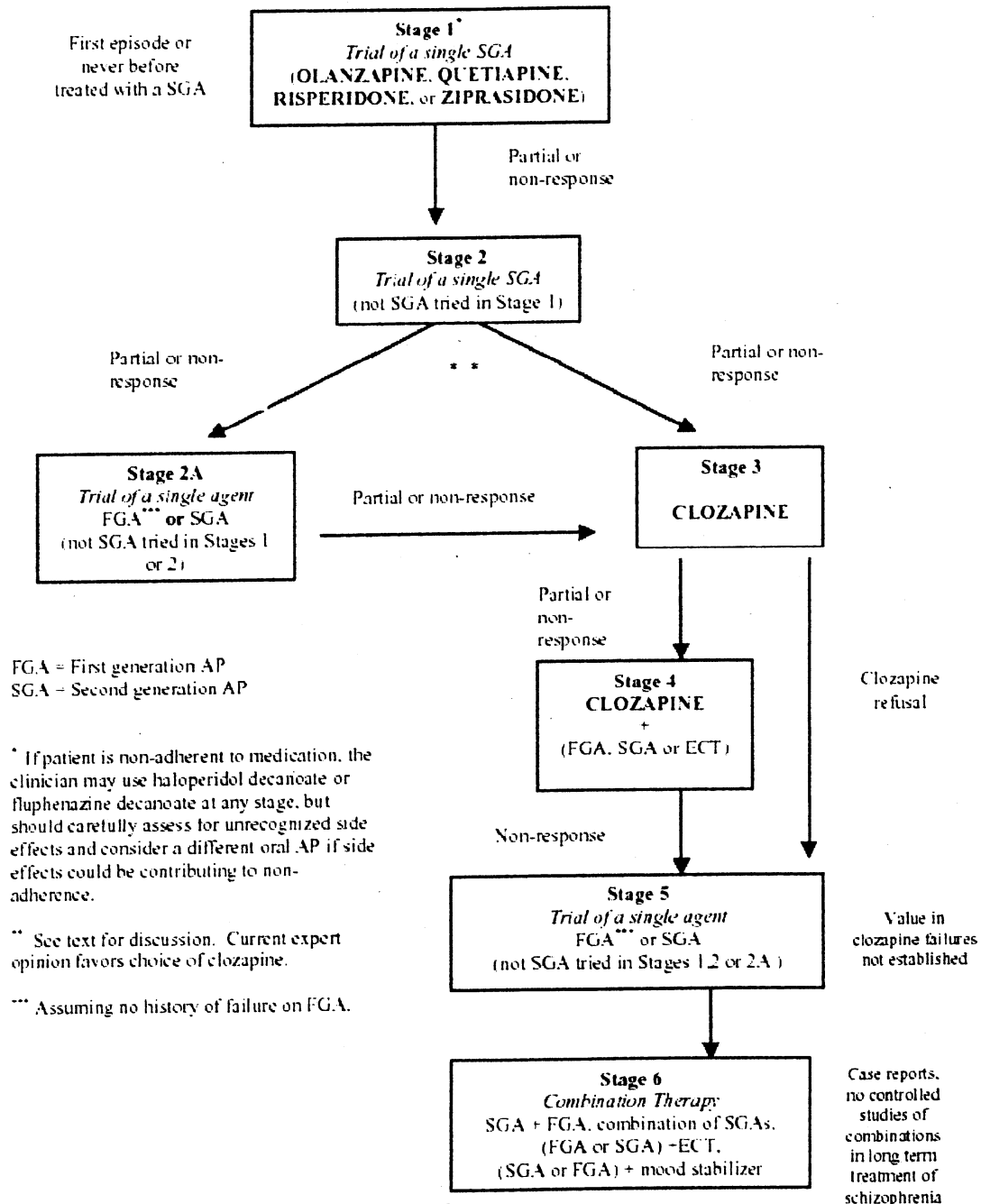
In addition, TMAP involves 1) a prospective comparison of the clinical outcomes and economic costs of using these medication guidelines with "treatment as usual" within the Texas MHMR system, and 2) implementation of these algorithms in the "real world" of the clinics and hospitals of the Texas Department of MHMR.<sup>11</sup>

The TMAP model uses algorithms (or step-by-step procedures) in the form of flow charts to help physicians deliver quality care based on making the best choice of medications and an assessment of their effectiveness. While algorithms do not dictate clinical answers, they provide a framework that clinicians use and which should yield similar treatment approaches in similar clinical situations.<sup>12</sup> The algorithms provide guidance regarding treatment regimens, including issues such as choice of "initial medication(s), initial dosage, dosage changes, methods to assess response to treatment, frequency of assessment and re-evaluation, and minimum and maximum treatment periods in order to assess adequacy of therapeutic response."<sup>13</sup> The algorithms were developed by systematically obtaining input from groups of clinicians, consultants, and consumers. Each algorithm was initially tested in five sites within the Texas public mental health system. The algorithm package consists of multiple components – patient education, frequent medical visits, medication availability, and consultation. The algorithm basically provides a framework for clinical decision making, with multiple options given (if possible) at each stage so that the patient's treatment plan can be altered to obtain optimal outcomes. There are a series of treatment steps that are determined by the patient's clinical response to the preceding step.

As an example, for schizophrenia, there are six stages of treatment in the current version of the algorithm (see Figure on next page and details in the TIMA schizophrenia physician's manual at <http://www.mhmr.state.tx.us/centraloffice/medicaldirector/timasczman.pdf>).<sup>14</sup> For patients experiencing their first episode of schizophrenia or who have never before been treated with a second generation anti-psychotic (e.g., olanzapine, quetiapine, risperidone, or ziprasidone), the first stage involves use of one of four different types of these second-generation anti-psychotic medications. If the patient responds favorably to the medication, the drug is continued and moved into a maintenance phase where indicated. If the patient does not respond favorably to the drug given at stage 1, he or she moves to stage 2, where a different one of the four types of

**Choice of antipsychotic (AP) should be guided by considering the clinical characteristics of the patient and the efficacy and side effect profiles of the medication**

Any stage(s) can be skipped depending on the clinical picture or history of antipsychotic failures



***State Pharmacy Plus Demonstrations  
Medicare Modernization Act —Final Rule  
Fact Sheet***

- Pharmacy Plus demonstrations are 1115 waivers that were designed for States to expand coverage for prescriptive drugs under the Medicaid program to seniors and individuals with disabilities who have income exceeding that permitted for Medicaid eligibility.
- The Centers for Medicare and Medicaid Services (CMS) approved four states' applications for Pharmacy Plus demonstration waivers (Florida, Illinois, South Carolina, and Wisconsin). The Pharmacy Plus program in Florida covers seniors between 88-120 percent of the Federal Poverty Level. The remaining three states cover individuals up to 200 percent of the Federal Poverty Level.
- The four-State demonstration waivers provide prescription benefits for 312,413 individuals, costing these States \$114 million per year, collectively.
- Generally, we believe that states can wrap around the Medicare Part D benefit and provide prescription drug coverage equal to or better than that under Pharmacy Plus at less cost to the state.
- The final rule provides that Pharmacy Plus demonstration waivers can continue with federal match after January 1, 2006, under certain circumstances.
- States that operate a Pharmacy Plus demonstration waiver must demonstrate these programs will still be cost effective by submitting a revised budget neutrality calculation for the demonstration. This calculation must account for the reduction in Medicaid spending and a lesser diversion of dual eligible beneficiaries into the Medicaid program due to the implementation of Part D. CMS will review the revised budget neutrality calculation and approve or disapprove the continuation of the demonstration for the period when the prescription drug benefit is effective.
- Pharmacy Plus program costs, including the state share of the program, cannot be counted towards true out-of-pocket costs because Pharmacy Plus programs do not qualify as State Pharmacy Assistance Programs.
- The Medicare Modernization Act of 2003 only allows a person or a State Pharmacy Assistance Program to make payments that will count toward true out-of-pocket costs for an individual Part D enrollee. Given this statutory provision, it is believed that in general States would be better off and would realize savings if those states restructured their prescription drug programs as State Pharmacy Assistance Programs, rather than continuing their Pharmacy Plus programs. Savings could be used in a variety of ways, such as directly paying for their enrollees' Part D premiums, wrapping around the Part D benefit by paying for the required cost-sharing, or paying Prescription Drug Plans for an enhanced benefit.

# Fact Sheet

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## CONSEQUENCES OF NON-TREATMENT

An estimated 4.5 million Americans today suffer from the severest forms of mental illness, schizophrenia and manic-depressive illness (2.2 million people suffer from schizophrenia and 2.3 million suffer from bipolar disorder). The National Advisory Mental Health Council estimates that 40 percent of these individuals, or 1.8 million people, are not receiving treatment on any given day.

The consequences of non-treatment are devastating:

- **Homelessness**

People with untreated psychiatric illnesses comprise one-third, or 200,000 people, of the estimated 600,000 homeless population. The quality of life for these individuals is abysmal. Many are victimized regularly. A recent study has found that 28 percent of homeless people with previous psychiatric hospitalizations obtained some food from garbage cans and eight percent used garbage cans as a primary food source.

- **Incarceration**

People with untreated serious brain disorders comprise approximately 16 percent of the total jail and prison inmate population, or nearly 300,000 individuals. These individuals are often incarcerated with misdemeanor charges, but sometimes with felony charges, caused by their psychotic thinking. People with untreated psychiatric illnesses spend twice as much time in jail than non-ill individuals and are more likely to commit suicide.

- **Episodes of Violence**

There are approximately 1,000 homicides – among the estimated 20,000 total homicides in the U.S. – committed each year by people with untreated schizophrenia and manic-depressive illness. According to a 1994 Department of Justice, Bureau of Justice Statistics Special Report, "Murder in Families," 4.3 percent of homicides committed in 1988 were by people with a history of untreated mental illness (study based on 20,860 murders nationwide).

The Department of Justice report also found:

- of spouses killed by spouse – 12.3 percent of defendants had a history of untreated mental illness;
- of children killed by parent – 15.8 percent of defendants had a history of untreated mental illness;
- of parents killed by children – 25.1 percent of defendants had a history of untreated mental illness; and
- of siblings killed by sibling – 17.3 percent of defendants had a history of untreated mental illness.

explicitly requiring plans to continue covering medications when a dual eligibles transitions to a Part D plan. NAMI pushed hard for such a requirement. While this requirement is not in the final regulations, the requirement for Part D plans to have transition policies in place should help ensure uninterrupted access to medications for most dual eligibles with mental illness. Nevertheless, NAMI will continue to press CMS to enforce such a requirement on drug plans beginning in 2006.

Another victory in the final regulations will allow states to use their Medicaid programs to "wrap around" limits in Medicare prescription drug coverage for dual eligibles. This will allow a state use Medicaid to continue covering medications that might be excluded from a Medicare PDP's formulary, including classes such as benzodiazepines that are excluded from the Medicare drug benefit.

~~Among~~ the other key provisions in the final regulations:

Dissemination of Plan Information - The final rules clarify that each PDP and MA plan will be required to disclose to all enrollees and prospective enrollees: the actual list of covered drugs, tiered cost sharing for all covered drugs, formulary functions and exception processes (i.e., how drugs not on the formulary can be accessed). CMS notes that it will also be reviewing all marketing materials.

Eligibility & Enrollment §8211; The final rule keeps in place penalties for late enrollment, i.e. individuals enrolling after May 2006 could face penalties that stay in place over time. However, dual eligibles and institutionalized persons are eligible for special enrollment status that allows them to avoid late enrollment penalties and switch plans without having to wait for the next once a year annual enrollment period.

Pharmacy & Therapeutics (P&T) Committees - The final regulations keep in place nearly all of the standards in the draft regulations on the P&T Committees that each PDP and MA plan will be establishing. The P&T Committees will be responsible for developing plan formularies and the placement of individual medications within a formulary (i.e., whether or not it is placed at a higher tiered co-payment level). While the decisions of P&T Committee regarding whether to include a drug on a formulary is binding, the decision on tiering is only advisory. This is disappointing in that the decisions made by P&T Committees (as well as the rationale used) will not have to be made public. The final rules note that CMS is planning to issue additional guidance clarifying that if a P&T Committee decides to use cost as a criteria for excluding or tiering a specific medication, it must consider total costs. This is important since it would allow for consideration of not just the cost of the medication, but the potential cost to the entire Medicare program (e.g., higher hospitalization that might occur if an innovative product is excluded).

Plan Formularies - In the final rules, CMS declined to mandate special rules applicable to certain classes of Part D enrollees. NAMI had advocated for inclusion of a requirement of an open alternative formulary for Part D enrollees with severe mental illnesses. The final regulations retain the minimum requirement for at least two drugs in each therapeutic class. However, if there are only 2 distinct drugs in a particular class, the plan could elect to cover only one. The final rules note that CMS will not require plans to cover off-label uses of FDA approved drugs. Instead, the final rules allow plans to require documentation for off-label use. In a positive development, CMS extended the advance notice period for mid-year changes to a plan's formulary from 30 days to 60 days. The final rules also state that a plan must transition enrollees on a product being removed from a formulary, to a product on the formulary. However, CMS declined to impose a binding "grandfather" requirement in cases where a product is removed from a formulary in the middle of a plan year.

True Out of Pocket Costs (TrOOP) - TrOOP is a critically important provision in the MMA that govern how plan enrollees will become eligible for more generous catastrophic coverage. TrOOP establishes the rules by which a plan enrollee can meet the requirement of spending \$3,600 of out-of-pocket costs, and thereby access significantly lower their co-payments. On the positive side, assistance from most charitable programs and certain state assistance programs (including programs offered by drug manufacturers) will be included in the calculation of TrOOP. Likewise, in cases where a pharmacy waives co-payment requirements, the amount of the waived co-payment will count as TrOOP. Unfortunately, the final rules maintain CMS's position that payments for a drug not on a

**TESTIMONY TO**  
**Joint Select Committee on Medicaid Reform**

**February 14, 2005**

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Dear Committee members:

My name is Dr. Alan Sadowsky and I am the Vice President of the Joseph L. Morse Geriatric Center in West Palm Beach. Joseph L. Morse is a faith-based organization that owns and operates a 280-bed nursing home, an adult day care center, a geriatric outpatient clinic, and a short-term rehabilitation unit. Morse is a highly respected facility with a 5-star ranking on the Agency for Health Care Administration Nursing Home Consumer Guide. Our chief operating officer, E. Scott Boord, and chief executive officer, E. Drew Gackenhimer have both been at the facility since its inception twenty-one (21) years ago. The former is presently the chairman of the Board of the statewide Florida Association of Homes for the Aged (FAHA) and the latter serves on the Board of Directors of our national association American Homes and Services for the Aging (AAHSA). In its history Morse has expanded its bed size, added an Institute for Geriatric Research and Training (that I direct) and now provides independent and assisted living so that it is a full service facility for seniors.

This afternoon, I wish to address the delegation on Medicaid reform as it relates to long-term care.

Governor Bush is recommending a \$200 million cut in reimbursement for nursing homes for fiscal year 2005-06. Adequate reimbursement goes hand in hand with quality and a nursing home's ability to hire and retain qualified staff. Currently, 95 % of Medicaid certified nursing

homes lose money because their Medicaid reimbursement does not cover their costs. In simple terms, there is no fat left to cut.

The 2004 nursing home budget cut, which was less than half of what the Governor is proposing for next year, placed an additional unfunded burden of \$341,618 per year onto Morse Geriatric Center's already hefty shortfall of \$41.66 per day (\$15,206 per year) per Medicaid resident. In past years, this short fall has been subsidized through foundation galas, caring family donations, philanthropic contributions, and earnings available to us through limited invested funds. Morse is unable to rely on these funding sources as a secure means for insuring care. As a mission driven, faith-based organization, the goal of Morse is to serve our clients based on need. Reduction in the Medicaid reimbursement rate threatens our ability to serve clients both rich and poor.

If Governor Bush's recommended cut of an additional \$200 million from the nursing home budget in 2005-06 is endorsed by the legislature, Morse stands to lose another \$12 a day per resident next year, increasing our annual loss to \$19,586 for each Medicaid recipient we serve. This means, Morse and most other nursing homes will not have funds to cover raises and bonuses to compete in the market place for qualified staff. In addition, we will not have the money to cover increases in the cost of insurance premiums and other services that are part of doing business. Something will have to give. We will probably be forced to reduce our participation in Medicaid and also cut back on quality of life services that are not mandated .

If the Legislature chooses to adopt Medicaid reform that embraces a managed care concept, we appeal to you that this be with input from providers like Morse. Absent careful implementation of the proposed system, providers like Morse Geriatric Center will be in severe financial jeopardy and people will have their access to faith based care seriously compromised.

We clearly understand the importance of addressing the growth in Medicaid costs, but we also believe that reform cannot be driven by money alone. We hope that controls will be built into the pilot to address quality, consumer choice, adequate reimbursement, a consumer friendly appeal process, and meaningful independent evaluation before the pilot is expanded statewide.

The experience at Morse with managed care has not been great. The system is cumbersome and complicated and seniors have difficulty navigating through the details. In the Jewish community, so many of our seniors (estimated at more than 70%) do not have a relative living in Broward, Palm Beach or Dade counties, so they feel particularly isolated and will not have local family member to advocate for services .

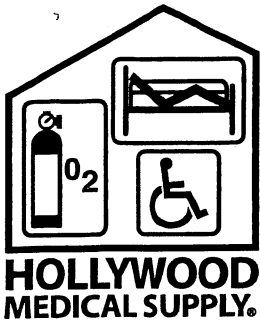
In order to save money on Medicaid, I offer 2 concrete suggestions for your consideration. HB 543 offers substantive reform on Medicaid eligibility. Currently many seniors are encouraged to “protect assets” and qualify for Medicaid through various legal procedures. This legislation will double the look back period for eligibility (from 3 to 6 years) and impose a stricter interpretation of passing assets to other family members simply to qualify for Medicaid.

In addition, pharmaceutical costs are large ticket item in the State Medicaid long term care budget. Morse Geriatric Center (Institute for Geriatric Research) completed a study on cost savings associated with automated dispensing and we believe that there are potential large savings associated with automated dispensing. Currently millions of dollars in medications are destroyed annually and automated dispensing could significantly change that. A key issue here are the costs associated with deploying these machines in the long term care facilities.

Medicaid reform cannot (should not) be taken lightly because of the number of lives it could hurt. We urge you to proceed with care and caution and factual detail to avoid hurting our must

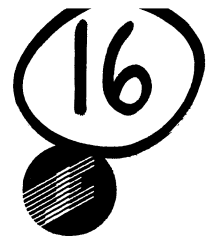
vulnerable citizens. Finally, we encourage you to build on the current long term care system rather than move to a privatized managed care model.

(END)



Ace Drug Inc., d/b/a  
**Hollywood Medical Supply Co.**

2131 Hollywood Boulevard  
Hollywood, Florida 33020-6828



**Joint Commission**  
on Accreditation of Healthcare Organizations

January 14, 2005

To: Members of the Senate & House Select Committee on Medicaid Reform

Ref: Medicaid Reform

Senators and Representatives, first I would like to thank you for taking the time to learn a little about our services, what it does and whom it serves.

My name is Robert Lichtenstein; I am President of Hollywood Medical Supply in Hollywood, Florida. We have been in business since 1965 and have been a Florida Medicaid provider since its inception. We are a JCAHO accredited provider for Home Medical Equipment, Clinical Respiratory Services and Rehab Technology Services. Our staff includes an orthotist, respiratory therapists, RESNA (Rehabilitation Engineering & Assistive Technology Society of North America) certified Assistive Technology Supplier (ATS) and Assistive Technology Practitioner (ATP).

We are commonly known as a durable medical equipment provider; our firm provides life support services, including ventilators, apnea monitors, oxygen equipment, surgical supplies, custom wheelchairs and orthotics to the South Florida community, by south Florida I am talking from Key West to the Ft. Pierce area; most of our clients are medically complex and fragile children. Many of our patients are under the case management Children's Medical Services provider network.

Previous to enrolling in CMS most of these patients were on some sort of managed care plan, however the complexity and costliness of their care has always made it unattractive for any sort of capitated system to care for them. We are talking about children who would have been in a pediatric nursing home or an acute care facility 5 or 6 years ago, but due to advances in technology and service provision we are now able to provide those life support services at home; at a lower cost to the state. I would like to mention that CMS, even with the existing reimbursement system can only find a few providers that will provide for their patients due to the acuity and complexity of services required for their clients.

I understand that you are looking at making changes in the Medicaid program, some of which would impact businesses such as mine. Should I need to contract or change our business structure in the future, we would do our utmost to become involved with such a provision of services.

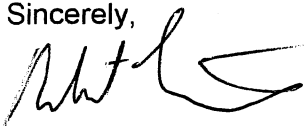
A number of DME providers have met with AHCA and all of us, including AHCA, have agreed on some proposed budget and legislative proposals this year. These include, the requirement for mandatory accreditation, an increase in the minimum liability insurance required for licensure and a 5% reduction in the current fee schedule. Please understand that we do not really want a 5% reduction, however we understand the constraints you face and want to do our part. Any cut beyond 5% could result in a reduction in the quality of services. Remember, when we fail, our clients either die or go back to the hospital. Credentialing for our industry is long overdue and needed if we are to take our place with the other health care service providers in Florida.

I am also asking that no provisos be added to the appropriations bill this year for sole source provision of services or competitive bidding projects. This year you are looking to overhaul to the present system. It makes no sense to try an experiment in one segment of the market, when you are looking to transition the whole system. There are already few enough specialized DME providers to choose from, wouldn't you want to promote competition by having the largest choice of qualified providers for the managed care entities to bargain with? With that in mind, any provisos to limit the number of providers this year, with the exceptions of those mentioned above, will limit the choices available next year for the proposed provider service network's.

To summarize, I am asking for credentialing, increasing the liability limits, and a fee schedule reduction that AHCA has agreed to as it fair and reasonable: also, a commitment not to have any provisos regarding pilot programs or limitation of DME providers other than by credentialing.

Thank you for your time and interest.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Lichtenstein', with a stylized flourish at the end.

Robert Lichtenstein  
President, Hollywood Medical Supply

**House and Senate Select Committee on Medicaid Reform**  
**Thomas Rozek, President & CEO**  
**Miami Children's Hospital**  
Monday, February 14, 2005

**1. Why Medicaid is important to Miami Children's Hospital and the children we serve**

As you have heard, Florida's Medicaid program currently provides health care coverage and services to over 2.2 million residents. Over half of whom are children. It might interest the Committee to know that, though children covered by Medicaid represent 50% of beneficiaries, they make up less than 20% of the actual cost of the Medicaid program. So, if the goal of reforming the program is partially, if not completely, based on managing costs, kids and their parents are not the main drivers. You also know that Medicaid the single largest source of federal funds coming to the state and brings in over \$2 billion in total business activities in Miami Dade County alone. This essential program provides comprehensive pediatric specialty health services to a diverse population, whom we have the pleasure to service at Miami Children's Hospital.

I agree with the Committee that there are ways that we can improve the Medicaid program and make it better and I applaud you for bringing us here today, and hope that there will be more opportunities to discuss positive innovations to the program. Today you have asked that we share our thoughts about the Governor's framework and some ideas for progress of our own. I am pleased to be here to do so.

**2. Questions of the Governor's Medicaid Reform proposal**

54% of the children we serve at Miami Children's Hospital are patients insured through the Medicaid program, many of whom suffer from chronic illnesses and acute physical and mental challenges. The Governor's proposal sets a framework for an unprecedented change in the Medicaid program in our state. I agree that we must look for ways to modernize the program and look forward to working with all of you, the Governor and his staff as well as my colleagues here in this room to make this program the best it can be. That being said, I have concerns that a wholesale shift to a capitated managed care system would harm those children whom we serve.

Looking specifically at the Governor's proposal I do have some questions that I hope the Committee will consider as you work through this important issue. The following three questions are a sample of a few issues that come to mind. First, the tiered system of care (basic, enhanced, catastrophic) described in the Administration's white paper appears to be based on a risk adjusted premium related to an individual's health status, which would be adjusted *annually*. While this might make sense for an adult whose health patterns had been generally established, but what would happen to a normal healthy child who in the middle of year is diagnosed with cancer? The Governor's proposal appears to place a cap on the *total* amount allocated to the Medicaid beneficiary, including the catastrophic component. What happens to this child once the allotment is

spent on an initial cancer treatment (chemotherapy and related services)? Is there a plan that the state will be proposing to address the requirements associated with treating children faced with unexpected acute medical needs?

Next, the healthy behavior model discussed in the Governor's proposal disproportionately affects children, who are not the ultimate decision makers of their health care. AHCA has stated that they would tie children's healthy behavior to that of their caretaker's but this would ultimately harm children if their parent's could not or would not ensure that healthy behaviors were employed. I have real concerns about potentially important services being denied to kids based on their parents' inaction and unhealthy lifestyles.

How will we be sure that actual savings are derived from changes in the Medicaid program for all of us who are involved? Looking at the \$60 billion in proposed federal cuts to Medicaid it is clear that the federal savings will, for the most part, will mean cost increases to the state and local government as well as physicians, other health care providers, hospitals and families. We must be certain that state-based reforms are not simply cost shifts to hospitals and other providers that will result in a hidden tax on employers who provide health insurance to their employees.

### 3. Innovations

My father used to tell me, "Don't come to me with a complaint unless you have some solutions." I have benefited greatly from his wisdom and I do come with some potential solutions to our problems that will improve the program and save the state money. Under the law, Medicaid is supposed to be the payer of last resort, yet because it tends to be a more efficient (time frame wise) payer, it often winds up paying for services that Medicare and private insurance are supposed to cover. States that have pursued this avenue have seen great savings in their program. For example, Connecticut has recouped over \$200 million from the Medicare program through pursuit of successful appeals of Medicare denials. These dollars have gone back into the Medicaid program.

Florida's prescription drug program represents 16.5% of the entire Medicaid budget and with Rx inflation rising faster than any other sector of health care it is sure to continue on that trajectory. Through your work, we have saved nearly \$500 million in the program but there is much more that can be done. Require disclosure of actual manufacturer's price (AMP) of a drug as a condition of doing business with the state. This is currently being done in Texas with great results. This would facilitate a competitive free market for prescription drugs. Have a state-of-the-art drug utilization review for high Rx users and target these recipients for disease management services, which, as the Governor points out, should decrease the risk of adverse reactions and subsequently the need for expensive hospitalizations.

There have been great breakthroughs and innovations in the medical community. In my world of children's medical care, for example, we have discovered that 90% of the

state's inpatient costs in pulmonary care are attributed to asthma and pneumonia. Experts at MCH, All Children's and other pediatric pulmonologists in the state have found innovative ways to treat children in the outpatient setting ...making recovery easier for them and less expensive for the state.

Indeed, providing incentives to pediatric specialty providers throughout the state who collaborate, develop best practice models that deliver quantifiable outcomes and cost effective service delivery systems to meet the acute care needs of children will not only result in savings but will improve the health status of all of our state's children. Innovations like this are present throughout the scope of disease and treatment and if they are employed can yield better outcomes, savings to the state and can help to modernize Medicaid without sacrificing its value. I look forward to working with all of you to find positive solutions to modernize Medicaid – making it a vital 21<sup>st</sup> century health program while maintaining its integrity for the 2.2 million children, seniors, people with disabilities and others whom it serves. Thank you for the opportunity to testify before you today.

# **BROWARD OLDER ADULT WORKGROUP**

"Advocates & Stakeholders focused on Aging, Mental Health & Substance Abuse & on improving Availability & Quality of mental health & substance abuse services for Broward County's elders."

## **RESPONSE TO FLORIDA MEDICAID MODERNIZATION PROPOSAL SENIOR HEALTH CHOICES PROPOSAL AND IMPLEMENTATION OF MANAGED CARE AND HMO BEHAVIORAL HEALTH SERVICES**

**SUPPORT Consumer Choice, Empowerment and Recovery as well as Quality and Adequate Care, Accountability and Predictability**

**SUPPORT Partnerships with Local Communities to Define and Establish Local Community Service Continuums and Networks that meet the Health Care Needs of Residents**

**SUPPORT Implementation and Adequate Resource Development of the Aging Resource Center and Aging and Disability Resource Center Programs passed through Senate Bill 1226 last session, particularly to accomplish the intent of the Senior Health Choices Proposal**

**SUPPORT Re-direction of County Nursing Home Medicaid Match to Fund Local Community-Based Services and Programs that Divert Nursing Home Placement**

**SUPPORT Improved Analysis of and Comprehensive Response to the Underlying Causes of Health Care Cost Increases**

**SUPPORT Sales Tax Exemption Reform to Generate Revenue Necessary to Adequately Support Needed Statewide Health and Human Services**

**SUPPORT Carve Out For Behavioral Health Older Adult Services**

**SUPPORT Mandatory Inclusion of Specialized Older Adult Behavioral Health Services**

**OPPOSE Creation of Numerous and Simultaneous "Pilots" and "Initiatives" Which Represent an Inefficient Distribution and Use of State Resources**

**OPPOSE Medicaid Modernization as Proposed**

"The 1<sup>st</sup> Regional Chapter of the Florida Coalition of Optimal Mental Health and Aging"

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# BROWARD OLDER ADULT WORKGROUP

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I, the undersigned, concur that the implementation of SB 2404 involve the carve out of funding for elder specific mental health and substance abuse services and/or the mandatory requirement and inclusion of these services as part of the funded managed entity network.

Name: <u>[Signature]</u>	Date: <u>10/23/03</u>
Name: <u>(COPIED) Wilby</u>	Date: <u>10/23/03</u>
Name: <u>Stephan Edmonston</u>	Date: <u>10/23/03</u>
Name: <u>Janette Jones Burian</u>	Date: <u>10/23/03</u>
Name: <u>Doris Windham</u>	Date: <u>10/23/03</u>
Name: <u>Nellie [unclear]</u>	Date: <u>10/23/03</u>
Name: <u>Adrian [unclear]</u>	Date: <u>10/23/03</u>
Name: <u>Pam [unclear]</u>	Date: <u>10-23-03</u>
Name: <u>Amonda [unclear] Thomas</u>	Date: <u>10-23-03</u>
Name: <u>Budget [unclear]</u>	Date: <u>10-23-03</u>
Name: <u>Mary R. Watson</u>	Date: <u>10-23-03</u>
Name: <u>Patricia Pullen</u>	Date: <u>10-23-03</u>
Name: <u>Jonathan [unclear]</u>	Date: <u>10-23-03</u>
Name: <u>Reel [unclear]</u>	Date: <u>10-23-03</u>

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Name: <u>Carol Heintz, RW</u>	Date: <u>10/24/03</u>
Name: <u>Sharon Marcus, SW</u>	Date: <u>10/24/03</u>
Name: <u>Frank Vanderloo</u>	Date: <u>10/24/03</u>
Name: <u>Amy Schwartzberg, LCSW</u>	Date: <u>10/24/03</u>
Name: <u>Jon Sechawen, RW</u>	Date: <u>10/24/03</u>
Name: <u>AT Rupp</u>	Date: <u>10/23/03</u>
Name: <u>Sherice Simmons</u>	Date: <u>10/23/03</u>
Name: <u>Vahid M. M.</u>	Date: <u>10/23/03</u>
Name: <u>Stanburger</u>	Date: <u>10/23/03</u>
Name: <u>Carren Renna</u>	Date: <u>10/23/03</u>
Name: <u>Paul Allman</u>	Date: <u>10/23/03</u>
Name: <u>Karen Parker</u>	Date: <u>10-23-03</u>
Name: <u>Jon Brasco</u>	Date: <u>10-23-03</u>
Name: <u>Myline Wolgin</u>	Date: <u>10-23-03</u>

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Name: <u>Maria Hernandez-Cruz</u>	Date: <u>10/23/03</u>
Name: <u>Sophia Smith</u>	Date: <u>10/23/03</u>
Name: <u>Yolanda E. Dault</u>	Date: <u>10/23/03</u>
Name: <u>Sarah F. Shuman</u>	Date: <u>10/23/03</u>
Name: <u>Annette B. Massey</u>	Date: <u>10/23/03</u>
Name: <u>Tommy Shuman</u>	Date: <u>10/23/03</u>
Name: <u>Julie Shuman</u>	Date: <u>10/23/03</u>
Name: <u>Susan Braen</u>	Date: <u>10/23/03</u>
Name: <u>Ampilla Fowler</u>	Date: <u>10/24/03</u>
Name: <u>Patricia Vandemark</u>	Date: <u>10/24/03</u>
Name: <u>Barbara Maman</u>	Date: <u>10/24/03</u>
Name: <u>Eva Serrano</u>	Date: <u>10/24/03</u>
Name: <u>M. Huley</u>	Date: <u>10/24/03</u>
Name: <u>Kelly Gable</u>	Date: <u>10/24/03</u>

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Name: <u>Cathy F. Bowers</u>	Date: <u>10/24/03</u>
Name: <u>Deanna M. Kelly</u>	Date: <u>10/24/03</u>
Name: <u>Diana Smith</u>	Date: <u>10/24/03</u>
Name: <u>Pat Fuller</u>	Date: <u>10/24/03</u>
Name: <u>John Mark</u>	Date: <u>10/24/03</u>
Name: <u>Bill Harts</u>	Date: <u>10/24/03</u>
Name: <u>Bella Laporte</u>	Date: <u>10/24/03</u>
Name: <u>Barbara J. West</u>	Date: <u>10/24/03</u>
Name: <u>Donna C. Citi</u>	Date: <u>11/21/2003</u>
Name: <u>Gaye Bluebird</u>	Date: <u>11/21/2003</u>
Name: <u>Therese A. Franzek</u>	Date: <u>11/21/2003</u>
Name: <u>Rose M. Wilkerson</u>	Date: <u>11/21/03</u>
Name: <u>Arnold Mark</u>	Date: <u>11/21/03</u>
Name: <u>[Signature]</u>	Date: <u>11/21/03</u>

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Name: <u>Ronald</u>	Date: <u>11/21/03</u>
Name: <u>Lara Hays</u>	Date: <u>11/21/03</u>
Name: <u>Maldine Broey, CCSW, CAP</u>	Date: <u>11/21/03</u>
Name: <u>Heather Lee</u>	Date: <u>11/21/03</u>
Name: <u>Patell</u>	Date: <u>11/21/03</u>
Name: <u>Gudyn Miller</u>	Date: <u>11/21/03</u>
Name: <u>Freddie Dennis Williams, MSW</u>	Date: <u>11/21/03</u>
Name: <u>Judith Rhallen</u>	Date: <u>11/21/03</u>
Name: <u>Calhoun</u>	Date: <u>11/21/03</u>
Name: <u>Boat</u>	Date: <u>11/21/03</u>
Name: <u>William Metcalf</u>	Date: <u>11-21-03</u>
Name: <u>Mary K. Helson (Mary K. Helson)</u>	Date: <u>11/21/03</u>
Name: <u>Daphne Henry</u>	Date: <u>11/21/03</u>
Name: <u>John Smith</u>	Date: <u>11/21/03</u>

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**The Florida Legislature**  
**Senate Select Committee on Medicaid Reform**  
**House Select Committee on Medicaid Modernization**  
**Public Hearing Comment Form**

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

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Name: Gaye Bluebird

Association: Advocacy Center for Persons With Disabilities

Address: 2901 Skilling Rd  
Ft Lauderdale FL 33312

(Please use the front and back of this sheet to provide your information.)

As a consumer Advocate of Mental Health  
recommend the following:

1- Involve consumers in development  
of new proposals.

2- Take a look at all consumer  
operated Drop In Centers - Save them!

3- Include us in developing  
Evaluation tools & evaluation  
process -

As a mother -

Please make sure my daughter  
receives medications she needs -

Evaluation of Behavioral Health Delivery Strategies:  
Focus Group for Florida Mental Health Institute

**Date:** March 10, 2004 10:00-12:00 AM  
**Held at:** Fort Walton Beach Mental Health Association  
**Participants:** Representatives from three mental health agencies in District 1:  
Lakeside Behavioral, COPE, Bridgewater

**Makeup of group:**

13 persons  
1 Asian or Hispanic (?)  
12 white  
7 female  
6 male  
Age range: 20-approximately 6



Florida's Protection and Advocacy Programs

**Gayle Bluebird, R.N.**  
Leadership Development &  
Training Specialist/Advocate  
Protection & Advocacy for  
Individuals with Mental Illness

2901 Stirling Road, Suite 206, Ft. Lauderdale, FL 33312  
tel. 954.967.1493 x215 • toll free 800.350.4566 • fax 954.967.1496 • TDD 866.478.0640  
www.advocacycenter.org • email: gayleb@advocacycenter.org

**Facilitators:**

Gayle Bluebird, Don McNair. Don explained the purpose of the focus group and passed out consent forms for people to sign. Gayle gave information about dialogue guidelines including need for courtesy, confidentiality, keeping comments short, and comments not focused on individual staff members or their names. Participants were given name tags so that facilitators could identify them by first name only.

**1. How pleased are you with the quality of services you receive?**

Most felt positive about staff.

One person said they overheard a staff member discussing clients in a bar.

Another person said that staff members ask too many questions.

Another reported that a staff member is hostile and bossy.

One person said, "I feel positive about my doctor." The doctor gave him the right medication.

**2. Regarding medications:**

Most were positive.

Three people indicated that they have had bad experiences with getting medications.

One person stated he had been waiting since Christmas to get his Medicaid card to cover an injury he had sustained.

Another person applied two months ago and was getting hospital bills. She waited 9 months to get medical approval

### **3. People helpful in getting services**

#### **Case Managers:**

All but one person felt positive about their case manager.

"Case managers are great. Whatever you need, they are there."

One lady said her case manager was not helpful and would not always provide transportation when she needed it.

One person: "My case manager is helping me and tries to solve my problems.

One lady said that the more independent you are the less care you get.

#### **Psychiatrists:**

Most people (8) felt good about their psychiatrists. Three did not.

One person said that her doctor never reads her file. She receives medication she would not take because of liver damage.

Person said he is seeing a doctor who serves children. "Doctor never listens to what I say."

Time: "They run you out of the office." No time spent with clients. Doctors don't spend much time with clients."

"Doesn't like Geodon and refused, which was later changed to Risperidol"

### **4. Drop-in Centers:**

One person knows about one at Bridgeway but you can only use it if you live there.

One person said she felt better when (Bridgeway) received her money—now she gets very anxious about it.

Four people live independently in the country. They were in agreement that support is needed however. People who are independent said the only place they have to go is the library.

Most people like the idea of "drop-in centers. (Some people indicated they did not know what drop-in centers were) Would like to see more of these in the county, particularly for those who are living independently.

### **5. Transportation:**

Bus transport is good.

Bus transportation is cheap.

Applying and waiting is the negative—but otherwise a good deal.

## **6. Other problems—Barriers to care?**

One person said he had to pay a \$3.00 co-payment for a physical. He was told that if he continued he would be fined.

One person was billed for \$105 from the center. She went to her case manager who is taking care of it.

“Bridgeway says if you don't pay they will turn it over to collections.”

One person stated that she had to pay \$175 personally besides Medicaid for stay in a CSU. She said because Medicaid does not pay enough.

“You can't go to the hospital on Medicare. Don't know where you go.”

“Bridgeway says if they don't get money they will drop you. It's wrong to intimidate you. I'm 60 miles from Bridgeway.”

## **7. Outings:**

Positive thing—everyone seemed pleased with the outings from their facilities.

One person likes COPE—goes out to eat, shopping. States COPE a safe place.

## **8. Transitions:**

Four people living independently.

Lady had negative experience: stayed with a friend after her release. The transition was rocky—had no case manager. Took a long time to get SSI.

One person said that it was rocky for him as well but he had the support of a case manager.

Another person: “Staff put themselves out to get us what we need—our own money.”

“Took me a long time to get SSI. I was staying by myself.

“Relationships are not encouraged at facilities.”

Another: Women living together failed. People went back to supervised living.

One person expressed difficulty with a case manager. Question raised by facilitator about grievance procedures and whether people knew how to use them?

One person filed a complaint—never got any feedback on whether the complaint was investigated.

“Agencies do not explain how to file complaints.”

“It's posted somewhere in the agency.”

One person filed a complaint that someone went through her “drawers.”—but she never heard anything back.

**8. Suggestions to make things better:**

(This section is a round robin for last comments—people can make comments or pass)

“Bridgeway needs more funding. Quality of services has dropped.”

“Hard to find out what’s going on about programs—more communication in the system is needed. More information about what other services—Needs a drop-in center in the community.”

“More self-help skills.” Job skills and training other than housekeeping jobs.

“Facilities need more money.”

“Need to screen employees better. Bring back regular socials. They have cut back on social services.”

“Would like bowling, shopping. Her facility does not do much. (Willow Way)

One person said he was an alcoholic but did not have any problems.

One person wanted to do something with ceramics (more arts activities)

“Need a hot meal at lunch. Overall programs good.”

“Need funding for dentists—can’t find a dentist who will assist.”

**Summary:**

Most people actively participated in the discussion. Some were more quiet than others though willing to share when asked. Themes that emerged were that people living independently needed more services and support. One person in this category may have just been in the CSU. She had artistic skills but had no place to get support for her work, though the Mental Health Association seemed to be helping her. People have no place to go with complaints though again, it was noted that MHA provides some telephone advocacy support for people who need to talk. Issues around billing for medical services seemed to be a problem for some. Either they were getting billed for co-payments, waiting for Medicaid or on Medicare that does not cover all of their expenses. It seemed that CMHCs did help them with their medical bills but not until people were quite frustrated and anxious with threats of being cut off medical services. Typical complaints emerged from persons who would like more variety in services available to them, particularly for those living in rural areas or who did not attend regular daily programs. The concept of drop-in centers was positive for them. They do not presently have one in District 1. They seemed pleased with case managers and psychiatrists, though some were having difficulties. (some of the more vocal participants were ones that seemed to have multiple problems) Overall the dialogue was positive and productive.

*Notes were taken by Gayle Bluebird and Don McNair.*

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House Select Committee on Medicaid Modernization  
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Name: Donna Sabatino, RN

Association: AIDS Healthcare Foundation

Address: 110 SE 6th St Suite 1960  
Ft. Lauderdale 33301

954-522-3132

(Please use the front and back of this sheet to provide your information.)

I fear the outcomes of privatizing the Medicaid  
system for the poor and disabled recipients.  
Providing services for this population for  
> 5 years, we have realized that putting  
food on the table or clothing on their  
families is a priority for our patients.  
Asking them to understand this very  
difficult health system and maneuver



and manage their own costs, is asking  
the "near impossible." What may seem  
as a way of reducing costs will  
actually create <sup>an</sup> increase as our HIV/AIDS  
patients end up in Emergency Dept's &  
(Urgent Care settings) as medications and  
outpatient care becomes more difficult  
to access. I feel if we focused on the  
fraud and abuse/misuse of Medicaid funds,  
increase the accessibility to fraud reporting  
and allowed recoupment of funds the  
Medicaid system would be more fiscally  
strong! You need to have community  
involvement from agencies like mine  
to help create a Medicaid system that  
works. Adding edits to the ACS payment  
system so <sup>pharmacy</sup> claims that are not authorized  
do NOT GET PAID! To date, that has not  
happened and AHF has been in touch w/AMA  
to offer such services for 2 years.

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Name:

FRANCESCA MARTINEZ

Association:

AFSCME FL Council 79

Address:

99 NW 183 RD ST STE 224  
MIAMI, FL 33169

(Please use the front and back of this sheet to provide your information.)

AS A PAST DCF EMPLOYEE IN THE

DEPT. OF ECONOMIC SERVICES I SAW

HOW THE PROGRAM DURING 1996 - 2002

WAS IMPLEMENTED. TOO MUCH COST

WENT INTO ADMINISTRATIVE INSTEAD OF

SERVICE TO THE COMMUNITY & CLIENTS.

REDUCING COST ON MEDICAID IS NOT

THE ANSWER. REDUCTION OF

IN FLORIDA  
NEW JERSEY

Front Line  
Employee is NOT the Answer.

My Mother Depends ON MEDICAID  
& MEDICARE to <sup>survive</sup> ~~serve~~ the ~~medical~~ <sup>medical</sup>

Condition of Diabetes. With you  
Thinking about cutting any  
MEDICAID Budget is Not the  
Wises of Thoughts - Lets Look  
At Other Ways to strengthen &  
provide more not less. Our Aging  
Population is in NEED lets not  
let them down since they have  
been tax payers for over 50 yrs.

According to workers that are still  
implementing MEDICAID & Medically Needy  
program there is too much <sup>Bureaucracy</sup> ~~Medicaid~~

IF WE CAN provide money outside to U.S.A  
than the Governor & our Legislative Body  
can ask for money Asst. for our State of  
Florida. ① Look @ Pharmaceuticals ② Look @ Doctors providers

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Name:

Nancy Linley-Harris (954) 581-4165 <sup>podsangels@bellsouth.net</sup>

Association:

parent of a boy w/ Down syndrome

Address:

1270 SW 28th Terr

H. Land. Hk. 33312

Down Syndrome  
Support Group

PODS Angels Support  
Foundation, Inc.

www.podsangels.org

(Please use the front and back of this sheet to provide your information.)

First of all I represent not only my

own little girl who is 6 years old w/ Down syndrome  
plus I am President & Founder of  
over 200 members to my PODS Angels Support

Foundation, Inc. (Parents of Down Syndrome) - My husband

& I are self-employed and can not afford health

insurance because of its high cost & because I

was treated for Eye Cancer 1 1/2 years ago <sup>WE DO NOT HAVE health insurance</sup>

so INS. Company will give me a policy, also because my  
daughter has Down syndrome - no insurance co will  
write us a family policy! Both my children

received Kid Care program - CMS & Vista. My son has ADHD and requires mental health services

my daughter receives her therapy thru CMS - OT - PT - ST and primary care services

★ To cut the medicaid program would put more of ~~on~~ a financial burden on our

family - I am still paying for my own medical out of pocket needs because of my wife's Cancer - required check ups to make sure we catch any other cancer metastasizing that is very possible to occur w/ me.

My children would not have <sup>their</sup> health care needs taken care of if it weren't for the Kid Care program - My daughter w/ her DS - she has 2-3 bouts w/ CROUP (closing off of her airway) a year & needs to make "middle of the night" trips to the Emergency room - if it weren't for her CMS services - I don't know how we would be able to stay in our home - being self employed - we are living from 1 paycheck to the next & without the Kid Care program & CMS - we could very easily be out of our home - and on the streets - Don't

... + ... AND ... FAMILY ...

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1. Employee of Kidney Foundation
2. Daughter of dialysis patient
3. potential dialysis patient

24

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Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review.

Name: Juliet Venezia  
Association: National Kidney Foundation of Florida  
Address: 2561 Coral Way 305-668-7758  
Miami, FL 33143 jvenzara@kidneyfla.org

(Please use the front and back of this sheet to provide your information.)

I represent the 19,000 dialysis patients in the state  
of Florida, as well as all transplant patients in Florida.

My own mother is a dialysis patient in renal failure and  
she is on the kidney transplant waiting list.

Currently, there are 700 dialysis patients on Medicaid  
who depend on Medicaid to SURVIVE. Like my mother, Ana.  
she, like many dialysis patients must take at least \$700 worth of  
medications per month for conditions associated with →

Kidney failure like blood thinners, blood pressure meds,  
anemia, bone disease, infection, malnutrition, supplements, diabetes,  
cardiac and thyroid diseases.

The GOOD NEWS is that <sup>chronic</sup> kidney disease is a PREVENTABLE  
illness for most forms of the disease. With education about  
blood pressure control, diabetes, drugs and diet we can slow and  
event prevent the growing population of dialysis patients.

As an exception to the preventable conditions, my mother has a non-preventable  
hereditary form of kidney disease; Polycystic kidney disease (PKD).

~~As~~ As her daughter, I have a 50% chance of having the disease.

As an ~~employee~~ employee of the National Kidney Foundation, who  
gives \$13,000 per month to dialysis patients & transplant patients  
who need <sup>financial</sup> assistance with medications, transportation and emergencies,  
I beg you to restore the Medicaid program to spare the lives  
of these patients. Although education & prevention are long-term  
savings plans for Medicaid/Medicare, I have also included points  
in the following attachments that point out serious problems  
and even solutions to the Medicaid dilemma.

Legislators, please read! Your constituent,  
Juliet Venzara

### Talking Points related to Quality, Access and Cost of Dialysis services for Medicaid Patients

As one of 700 Medicaid dialysis patients in Florida, I am concerned about access to quality care caused by Florida's Medicaid low reimbursement of dialysis treatment, medications available to dialysis patients and the current process for drug dispensing, administration and reimbursement. I am also concerned that the Governor's proposed Medicaid Modernization plan will further cut benefits that are critical to the ESRD patients.

#### Access to quality Dialysis Treatment and Management of ESRD and associated diseases

ESRD = end stage renal disease = ON DIALYSIS

- Florida currently has one of the lowest Medicaid ESRD dialysis treatment rate payments compared to all other states nationally. This is causing an issue with access and quality of care.
- Many outpatient dialysis facilities are being forced to turn down Medicaid patients because they cannot afford to provide the care.
- At outpatient dialysis facilities under the primary care of a nephrologist, ESRD patients have access to a team which includes dieticians, nurses, social workers and health care technicians who specialize in the management of ESRD and other diseases associated with it. This team is responsible for establishing a comprehensive plan of care that is designed specifically for each ESRD patient's needs related to kidney failure and other conditions, such as bone disease and anemia.
- Medicaid patients that are turned down by outpatient dialysis facilities are dialyzed in hospitals. In the hospital setting, patients only receive the dialysis treatment. Florida Medicaid ESRD patients are denied access to a team of dialysis professional experts that can improve their total health through a coordinated care plan.
- Dialysis patients are an operational and financial burden to hospitals.

#### Reimbursement of ESRD Drugs other than Epogen

- An essential part of the ESRD patient's plan of care consists of the administration of medications designed to treat ESRD and its many associated medical conditions, such as anemia, bone disease, infection, malnutrition and diabetes, as well as cardiac and thyroid disease.
- Medications are prescribed by the attending nephrologist and administered to the ESRD patient at the dialysis facility.
- Frequent medication adjustments are made by the nephrologist to optimize the ESRD patient's clinical outcomes.
- Medicare (as well as most other state Medicaid programs) allows the outpatient dialysis facility to directly obtain, administer, and receive

reimbursement for medications administered in the dialysis facility to ESRD patients.

- Contrary to these standard reimbursement practices, however, Florida Medicaid only allows outpatient dialysis facilities in Florida to directly obtain, administer and receive reimbursement for one medication: Epogen.
- In Florida, the burden is placed on the ESRD patient to: (1) go to a compounding pharmacy to obtain his or her medications for treatments such as anemia, and antibiotics for infections; and (2) bring such medications to the dialysis facility for administration and monitoring by health care personnel causing, among other things, a delay in the ESRD patient's care, administration and coordination.
- Effective drug therapy for kidney-related bone disease is not available to ESRD Medicaid patients.
- Often, patients fail to obtain such medications in the time prescribed by the patient's nephrologist. As such, a delay in drug administration may lead to medical complications.
- Allowing dialysis facilities to directly obtain, administer and be reimbursed for medications (consistent with the current practice for Epogen) will improve the quality of care for Florida ESRD patients and improve patient outcomes.

# Florida Medicaid ESRD Program Misunderstood And Poorly Funded Causing Inappropriate Use Of AHCA Funds



## Current Situation

At any point in time there are approximately 675 Medicaid eligible patients who have kidney failure and need outpatient dialysis treatments in the State of Florida. These patients are either waiting to become eligible for Medicare or will NEVER be eligible for Medicare due to no work history and do not qualify under a spouse or parent.

These 675 patients are referred from hospitals to the approximately 280 outpatient dialysis facilities in the State. There are less than 6 hospitals in the state that continue to offer outpatient dialysis services.

Currently, Medicaid pays \$85.00 for a hemodialysis treatment performed at freestanding outpatient facilities, allowing three treatments per week. A prorated amount of \$36.00 per day is paid for a home peritoneal dialysis patient dialyzing seven days a week. The only other service paid to dialysis facilities is for Epogen, an anemia medication.

## I. Improve Access To Care For Medicaid ESRD Patients

- ESRD Patients are currently being denied access to free standing facilities causing increased costs to AHCA due to extended Hospital Lengths of stay. Florida's Medicaid Program only reimburses \$85.00 per Dialysis treatment, the lowest rate of any US state Medicaid ESRD program. This rate must be increased to at least the average Medicare rate of \$130.00 per treatment. Med PAC's report to Congress in 2004 stated the Current ESRD Medicare rates only cover 98% of the costs of providing the treatment; the Florida Medicaid rate only covers 65% of the cost. The Medicare treatment rate is to increase by 1.6% January 1, 2005. Florida Freestanding facilities can no longer absorb the loss of \$50/tmt, or approximately \$10,000 loss per year per Medicaid ESRD patient.
- Expand the Medicaid formulary to include Vitamin D analogs, injectable iron and other ESRD therapies to be more aligned with the CMS ESRD Medicare formulary. Currently Medicaid ESRD patients are not receiving these medications, which leads to increased risk of hospitalization, morbidity and mortality.
- Establish a Medicaid outpatient reimbursement rate for blood transfusion services; currently patients are hospitalized unnecessarily for transfusion services.

- Allow illegal aliens with ESRD to receive Florida Medicaid without having to qualify through the Emergency Medicaid program. This program was not intended for ESRD Patients, qualification is a very lengthy process, delaying admission to outpatient facilities and increases cost of hospitalization.

## **II. Exempt Medicaid ESRD Patients From Single Vendor Laboratory Proposal And Support Physician Choice To Select Laboratory Services Of Their Preference**

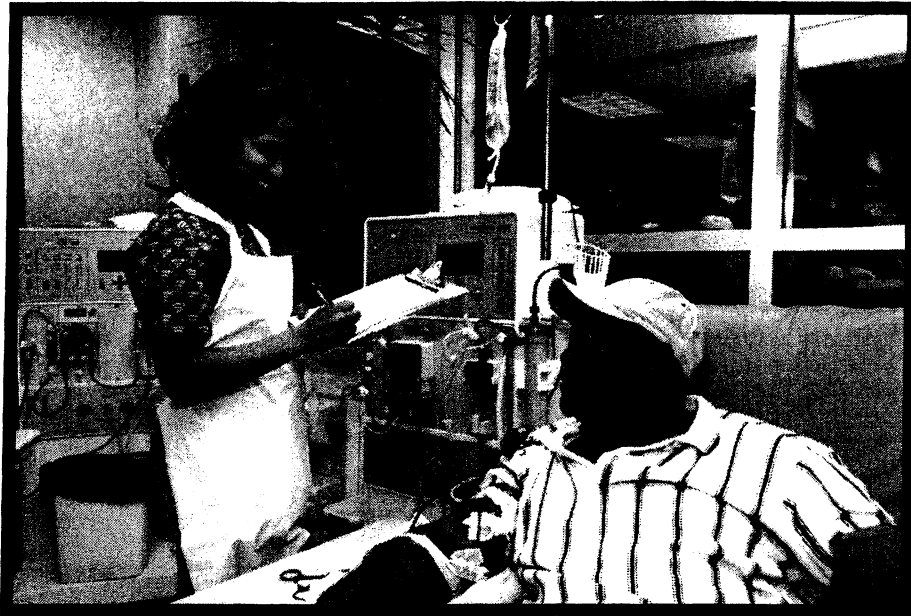
- CMS requires dialysis facilities to report facility specific aggregate quality indicators of all ESRD facilities; this cannot be achieved if lab for Medicaid ESRD patients is mandated to a single lab provider. This will fragment the dialysis facility's ability to trend and track quality of care indicators and would compromise the integrity of the aggregate lab values, as well as causing increase administrative cost to comply with such a mandate.
- Referring nephrologist should be allowed to referred specific lab tests to the lab of their choice, and not be mandated by the State on which lab there are to utilize. Lab work for patients with ESRD is very specific and should be referred to dialysis specific laboratories.

## **III. Average Direct Costs per Dialysis Treatment**

For the \$85.00 per hemodialysis treatment, the dialysis facility is expected to provide the following CMS mandated services. Due to high costs of recruiting and retaining nurses, the labor component alone is now exceeding \$85.00 per treatment in most Florida areas.

- Registered Nurse and trained patient care technician care for the 4 hour treatment
- Masters prepared social worker services
- Registered Dietitian Services
- Disposable supplies, equipment and overhead for the dialysis treatment such as:
  - Dialyzer – Costs range from \$12.00 - \$30.00 per treatment depending on the medical needs of the patient.
  - Blood Tubing
  - IV solutions – Saline
  - Needles and syringes
  - Sterile dressing changes for access site
  - Medications such as heparin, mannitol, hypertonic saline, and many others included in the composite rate
  - Dialysis machine and testing equipment
  - Treated water for the dialysis treatment

These are all direct costs on providing each treatment. Other indirect costs include facility's rent, taxes, utilities, housekeeping and medical directorship oversight.



### Case Study On How To Save AHCA Money

- Florida Hospital Based ESRD programs are paid a much higher rate than freestanding facilities:

Shands Healthcare System, Gainesville	\$203.78/tmt
Florida Hospital, Orlando	\$140.08/tmt
St Lukes Hospital, Jacksonville	\$145.15/tmt

All Freestanding Florida ESRD facilities     **\$85.00/tmt**

- Source AHCA January 2004:

[http://www.fdhc.state.fl.us/Medicaid/cost\\_reim/hospital\\_rates.shtml](http://www.fdhc.state.fl.us/Medicaid/cost_reim/hospital_rates.shtml)

- Example, Shands, in Gainesville, has approximately 25 Medicaid primary pts, if AHCA would reimburse the Gainesville area freestanding dialysis facilities, the average Medicare rate of \$130/tmt, AHCA would save \$276,675 per year, just in Gainesville!

- ✓  $\$203.78 - \$130 = \$73.78/\text{tmt}$  difference (savings per tmt)
- ✓  $\$73.78 \times 25 \text{ pts (Shands Medicaid ESRD pts treated at freestanding facilities)}$   
 $\times 150 \text{ tmts/yr} =$

**\$ 276,675 Savings to the AHCA ESRD Program,  
and that's just in Gainesville !!**

# Medicaid ESRD Reimbursement Ranking

State		Per Treatment Rate
1	Florida	\$85.00 ← What?
2	Alabama	\$97.09
3	Georgia	\$112.93
4	Maine	\$114.48
5	Missouri	\$115.00
6	Pennsylvania	\$115.00
7	Rhode Island	\$116.00
8	Mississippi	\$117.00
9	New Hampshire	\$117.17
10	Illinois	\$121.24
11	South Carolina	\$121.44
12	Kentucky	\$122.45
13	North Carolina	\$124.06
14	Oklahoma	\$124.21
15	West Virginia	\$125.40
16	Louisiana	\$125.70
17	Connecticut	\$129.88
18	Arkansas	\$130.00
19	Kansas	\$130.00
20	Indiana	\$130.91
21	Ohio	\$131.37
22	Hawaii	\$131.39
23	Nevada	\$135.41
24	Maryland	\$136.17
25	Virginia	\$138.00
26	California	\$141.31
27	Michigan	\$148.43
28	New York	\$150.00
29	Washington	100% U&C

New Jersey	Medicare
Texas	Medicare
Massachusetts	Medicare
Wisconsin	90% of U&C
Tennessee	Medicare
Delaware	Medicare
Colorado	Medicare
New Mexico	Medicare
Arizona	Medicare
Oregon	Medicare
Minnesota	Medicare

**January 2005 Florida Medicaid Modernization Proposal Talking Points**  
**Revised January 19, 2005**

On January 11, 2005, Governor Jeb Bush released his Florida Medicaid Modernization Proposal. Here are some of the key problems with it:

- **Jeopardizes access to critical health care services.** The proposal provides no guarantees that those who rely on Medicaid will have access to critical health services. There are no clear standards that determine the benefits plans should provide. Bureaucrats from HMOs and other managed care organizations will have the final say on the kind of coverage people get.
- **Puts the most vulnerable Floridians at risk.** Medicaid was created to provide a safety net for those portions of the population—seniors, disabled, and children—that are most in need of a helping hand. This proposal undermines the security that Medicaid provides by requiring that individuals fend for themselves. With no protections against “cherry-picking” or guarantees of other protections, health plans are free to deny coverage at whim.
- ★ • **Shifts costs to counties, providers, and participants.** Since the proposal caps the coverage each enrollee receives, the cost of care will ultimately be shifted back to counties, hospitals, and other safety net providers. Already pinched, these providers will not be able to cover this need and those who rely on the program are not able to fill gaps.
- **Leaves rural Floridians in the lurch.** The proposal leaves it up to HMOs and other managed care organizations to decide where they want to provide care and to whom. There is no guarantee that health plans will be available in rural areas. How will the state ensure that rural Floridians have access to health plans and health care services?
- ★ • **Empowers health plans, not patients.** The proposal says it is empowering patients, but in reality there are no guarantees that patients will get the health care they need. But, it says that the state will provide only “minimum guidance” on the type of and how much health care plans will provide, leaving critical health coverage decisions at the discretion of HMO bureaucrats. HMOs can bail out of providing key services for a variety of reasons, including insufficient profit.
- ★ • **Provides the wrong incentives.** The proposal provides incentives for people to forgo enrolling in health coverage now in order to save their Medicaid allotments for the future. But, what happens if people get sick or need health care now? Also, providing plans with very limited coverage is a very costly mistake. People will avoid getting care in the short-term, and end up needing more expensive care in the long term, which will cause health care expenses to increase.
- **Adds more administrative costs.** The proposal is so complicated that it requires the establishment of an “information infrastructure” to help people select plans and providers.

**January 2005 Florida Medicaid Modernization Proposal Talking Points**  
**Revised January 18, 2005**

The state will also determine how much each person can spend on their health care and develop a system to rate plans. The addition of these new procedures will result in significant administrative costs and unnecessary bureaucracy.



- **Fails to address the underlying causes of health care costs increases.** Cost increases both in the private market, and in Medicaid (which is growing at a slower rate), are due to factors such as the rapidly increasing cost of prescription drugs, hospital care, and the large number of Floridians who have no access to health insurance. The Governor's plan does not appear to address these critical issues.
- **Creates a maze for people to navigate.** The proposal lists a complex set of plan choices and options. Some of these options only provide "basic care," others provide "catastrophic coverage" and "enhanced benefits." How will people choose what combination of plans to enroll in? Will the state's information simply steer people into the least costly option?

**NKF** National Kidney Foundation®  
Of Florida, Inc.

JULIET VENZARA  
COMMUNITY OUTREACH COORDINATOR  
Cell: (786) 295-5080

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(305) 854-5690 • FAX (305) 854-4131 • (800) 976-0772  
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**The Florida Legislature  
Senate Select Committee on Medicaid Reform  
House Select Committee on Medicaid Modernization  
Public Hearing Comment Form**

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

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Name:

Elba Ramos Sanchez

Association:

21205 NE 37 Dr #603

Address:

Aventura FL 33180

(Please use the front and back of this sheet to provide your information.)

Yo soy la abuela de  
John Stephens Jr. Como abuela  
que siempre me ha preocupado  
el bienestar de mi nieto  
me opongo firmemente a la  
reforma de Medicaid

**The Florida Legislature**  
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**House Select Committee on Medicaid Modernization**  
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Name: Eileen Roth  
 Association: Parent / Legal Guardian  
 Address: 701 Carrotwood Ter  
Plantation, FL 33321

(Please use the front and back of this sheet to provide your information.)

→ "Autistic"  
Representing my adult son Andrew  
Andrew lives at a <sup>behavioral</sup> group home in  
Fort Lauderdale. He depends on ~~the~~ medication  
and medical care that Medicaid pays  
for. Please do not make any  
changes in his Medicaid funding.  
Andrew Roth — <sup>peaceful</sup> Haver Ranch  
12601 Stirling Road  
Fort Lauderdale, FL 33330

**The Florida Legislature  
Senate Select Committee on Medicaid Reform  
House Select Committee on Medicaid Modernization  
Public Hearing Comment Form**

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Name:

Stanley Shapiro

Association:

(NAMI)

Address:

1817 102 Way South  
Boca Raton, FL 33498

(Please use the front and back of this sheet to provide your information.)

IT IS ESSENTIAL THAT MENTALLY ILL PATIENTS  
HAVE CONTINUED OPEN ACCESS TO THE LATEST DRUGS  
AVAILABLE.

IF THESE PATIENTS DO NOT GET THE LATEST  
DRUGS, THEY WILL DEGRADATE INTO HOMELESS,  
HOMELESSNESS, INSTITUTIONAL CARE AND CRIME. THE  
COSTS WILL EXPLODE BEYOND THE PRESENT COST  
OF CURRENTLY USED DRUGS. 1 WEEK IN A HOSPITAL

**The Florida Legislature  
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Name: Linda Mills

Association: ADA Working Group

Address: 4411 NE 21 Ave

PLANTATION, FL 33308

(Please use the front and back of this sheet to provide your information.)

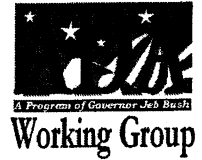
The Medicaid Diversion Cost Containment Program

is a proposed method to divert new enrollees from utilizing  
Medicaid services. This program is an effort to provide  
minimal assistance to those who can no longer maintain all  
costs of their disability while living independently. Many who  
face this issue have no choice but to give up living  
independently pursuing their maximum potential in the community  
or quit their jobs and go on Medicaid for assistance with  
their disabilities needs.

A Medicaid Cost Containment Diversion Program establishes  
a method for the state to provide minimal assistance  
to individuals with disabilities who need help to  
remain independent, working and contributing taxpayer.  
the ADA requires that people with disabilities have services  
provided in the most inclusive settings possible. The  
Personal Care Attendant Program is a way to help pay  
for costs of this at-home care for individuals  
of disabilities. Take a look at the current pilot  
program created by Senator Wise allows uncollected  
tax dollars to be collected with the eventual goal of  
providing a personal care attendant assistance to people  
who are spinal cord injured thru the Brain + Spinal Cord Injury  
viewer program for those people who are fiscally eligible  
under the current system who require state assistance for  
reprovision of their care. This project needs to be expanded  
statewide + made available<sup>able</sup> for all people with  
disabilities in the state who need this level of  
Care.



# FLORIDA DEPARTMENT OF MANAGEMENT SERVICES



**JEB BUSH**  
Governor

**ROBERT H. HOSAY**  
Interim-Secretary

## Federal Initiative for Consideration in Florida's Medicaid Reform

### ADA Working Group Position Paper February 10, 2005

The President's budget for 2006 includes initiatives that should be adopted and/or prepared for as Florida proceeds with Medicaid reform efforts<sup>1</sup>. These initiatives are part of the President's New Freedom Initiative, the goal of which is to promote inclusion of individuals with disabilities in the community.

Specifically, the proposed initiatives include the following:

- "Money Follows the Person": Under the proposed "Money Follows the Person" demonstration, Federal grant funds would pay 100 percent for the first year for home and community-based waiver services for individuals who move from institutions into at-home care. As a condition of receiving the 100 percent federal match, the participating State would agree to continue care after the first year at the regular Medicaid matching rate and to reduce institutional long-term care. Creating mechanisms for funding community-based services is critical to successful programs that transition people from institutions to the community.
- Home and Community-Based Care Demonstrations: The Budget includes three demonstrations proposals to encourage home and community-based care for children and adults with disabilities:
  1. Community Alternative to Children's Residential Treatment Facilities: This demonstration enables States to offer home and community-based services to children who would otherwise be served in psychiatric residential treatment facilities. This would permit the delivery of intensive mental health services for children in their homes and communities and allow the HHS to evaluate the cost of providing these services outside of institutions.
  2. Respite for Caregivers of Disabled Adults: This proposal creates a demonstration that tests whether respite care, or temporary care, reduces primary caregiver "burn-out" that often leads to institutionalization of individuals with disabilities.

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<sup>1</sup> The President's budget proposal for HHS can be accessed from the HHS website at:  
<http://www.hhs.gov/budget/docbudget.htm>. Information about the New Freedom Initiative can be found at  
<http://www.cms.hhs.gov/newfreedom/>.

3. **Respite for Caregivers of Children with a Substantial Disability:** This demonstration allows States to provide respite care to care givers of children with substantial disabilities. The demonstration would enable the Department to collect specific data about the cost and utilization of respite services for caregivers of disabled children.

- **Spousal Exemption:** This proposal protects Medicaid coverage of an individual married to an individual with a disability participating in a work incentive program under the Social Security Act. Currently, if an individual is Medicaid eligible and the individual's spouse participates in the program, the spouse's earnings could cause the individual to lose his/her Medicaid coverage.
- **Presumptive Eligibility:** Establishes a State Medicaid option allowing presumptive eligibility for institutionally-qualified individuals who are discharged from hospitals into the community. This will increase the number of Medicaid beneficiaries who receive home and community-based services rather than institutional care. This proposal has no cost associated with it. Streamlining the eligibility process will enable individuals to avoid unnecessary institutionalization while they wait to be determined eligible for Medicaid.

If implemented in Florida, these initiatives will give people with disabilities and their caregivers supports and services needed for successful community inclusion.



**JEB BUSH**  
Governor

# **FLORIDA DEPARTMENT OF MANAGEMENT SERVICES**



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Interim-Secretary

## **Medicaid Diversion Cost Containment Program**

### **ADA Working Group Position Paper February 10, 2005**

The Medicaid Diversion Cost Containment Program is a proposed method to divert new enrollees from utilizing Medicaid services. This is not a required program of the federal government. Florida is improving our efforts to divert people from nursing home level of care through many efforts. Unfortunately, our efforts have overlooked a segment of people with a variety of disabilities who most importantly are currently gainfully working, living independently and paying taxes, etc. **Most of Florida's efforts have been to improve the ability of people with disabilities to have meaningful participation in the development and planning of their services with varying degrees of informed choice and decision-making for existing consumers or those waiting for services.**

The Medicaid Diversion Cost Containment Program would be an effort to provide minimal assistance to those who can no longer maintain all costs of their disability while living independently. A common scenario in Florida is illustrated below. Unfortunately, it is not an isolated case.

Case Example: Single, forty-five year old, beautiful, young woman with disabilities who currently resides in Orlando. She works for one of Florida's leading entertainment parks and makes \$45,000 annually. She has a Masters Degree, uses a wheelchair, has no strength in her legs and limited arm usage thus requiring full time care due to her inability to transfer from bed to wheelchair, perform daily living skills and toilet herself independently. The cost of maintaining her disability actually leaves this successful, thriving woman relying on family to make ends meet each month.

Specific costs to maintain her disability include: \$1,200 – 1,500 per month in personal care attendant services that are utilized at work, home and her community; \$400 per month in student loans; maintenance of her service animal; maintenance of her electric wheelchair and other equipment that provides the maximum independence possible; special dietary needs which results in double the cost of regular food, and deductibles for physical therapy; van insurance for a modified van she drives herself. She also pays rent utilizing no subsidized housing program and all the other typical cost of living expenses.

*Linda Mills, Chairperson • Julie M. Shaw, Executive Director*  
*Americans with Disabilities Act Working Group • 4030 Esplanade Way, Suite 315, Tallahassee, Florida 32399-0950*  
*Telephone: 850-487-3423 • Fax: 850-414-8908 • TTY/Toll Free: 877-232-4968*  
*www.abilityforum.com*

She is receiving no assistance from the State of Florida while she pays Medicare, federal tax, and social security as an individual. She is double taxed by the federal government for the funds she uses to purchase her personal care attendant services. She pays federal tax on all earnings and then is taxed again on the same funds she uses to pay payroll tax for the employment of her personal care services.

The challenge is that she can no longer make all of the ends meet as her disability related expenses, specifically her personal care attendant services, continue to rise with other costs of living. She is at the point where she has to decide to give up living independently pursuing her maximum potential in the community or **QUIT HER JOB AND GO ON MEDICAID FOR ASSISTANCE WITH HER DISABILITY NEEDS.**

Unable to continue to go to work and make ends meet due to the unique disability relates expenses, these individuals will have no choice but to go on Medicaid and other state/federal programs. In essence, she would eventually become 100% supported by state funding and federal funding.

The Medicaid Cost Containment Diversion Program establishes a method for the state to provide minimal financial assistance to people with disabilities who just need a little break to remain independent, working and a contributing tax payer.

The goal of the ADA is to provide people with disabilities the opportunities to live as independent, productive members of society. The ADA requires that people with disabilities have services provided in the most inclusive setting possible, free from discrimination in employment, public services, public accommodations and transportation. **With appropriate supports and services, and the protections of the ADA, individuals with disabilities are productive, independent, tax-paying members of the community. Failing to provide the services necessary to promote independence and productivity is bad public policy, particularly when a better choice is available.**

The Medicaid Diversion Cost Containment Program (MDCCP) will enable individuals with disabilities to avoid Medicaid services. Every person who receives help under the MDCCP is one fewer person added to the Medicaid rolls. In the face of skyrocketing Medicaid costs, keeping people off Medicaid is good public policy.

The first step the legislature can take is to assure a Personal Care Attendant Program is available for Floridians like the case sample provided. There are several different approaches the legislature may consider:

- The current pilot program created by Senator Wise allows uncollected tax dollars to be collected with the eventual goal of providing a personal care attendant assistance to people who are spinal cord injured through the Brain and Spinal Cord Injury Waiver Program for those people who are fiscally eligible under the current system who require state assistance for the provision of their care. To bring forth the full effectiveness of that project, the program needs to be expanded this year statewide and made available for all people with disabilities on state program who require this level of care.

- For those Floridians who receive no assistance from the state, in order to avoid becoming Medicaid eligible, the state should consider some form of fiscal assistance whether that be a reimbursement after the fact for personal care attendant costs at 50% cost or a sliding scale assistance program to divert the individual from our Medicaid rolls and contain the costs for the future while the individual continues to work and pay taxes.
- The legislature may choose an income limit for the Medicaid Cost Containment Program which should take into consideration the various costs of maintaining disability independence but potentially as long as the individual is doing well in their employment, with promotions, etc. the assistance will not be needed indefinitely.
- To address the issue of the person with a disability being double taxed when they hire attendant care services, the state should consider establishing a pretax attendant care expense program similar to the pretax program offered to employees under the state's benefit system. This would allow the person hiring attendant services to set aside those dollars prior to payroll taxing. The option of this type of service should be added to the current employee pretax program and the state should create a method to offer the same opportunity to people outside of state employment to avoid further increasing unnecessary Medicaid program costs.

Every person who receives help under the MDCCP is one fewer person added to the Medicaid rolls. The person with a disability would be able to pay their attendant a better wage, which in turns reduces the turnover in attendant care that results in a better quality of health. In the face of skyrocketing Medicaid costs, keeping people off Medicaid is a good public policy.

**The Florida Legislature  
Senate Select Committee on Medicaid Reform  
House Select Committee on Medicaid Modernization  
Public Hearing Comment Form**

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately \$14.4 billion (24% of the entire state budget) and are projected to more than double to \$36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

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**Name:** KIMBERLEY BUSA  
**Association:** Child and Family Connections (CFC Agency)  
**Address:** 3333 Forest Hill Blvd.  
West Palm Beach, FL 33406

*(Please use the front and back of this sheet to provide your information.)*

Hello. I'm representing the Community Based Care  
Agency in West Palm Beach. I would like to  
ask you to keep funds for services for  
dependent children (foster kids) with  
CBC's. The needs of dependent children  
are very complex and unique. CBC's  
are able to tailor and creatively  
use funds for services for dependent



children.

Please consider keeping funds for dependent children with the Community Based Care Agencies. We know our children individually and can use funds to meet their very unique needs.

Thank you,

Kari BOSA, L.C.S.W.

Kari Bosa, LCSW

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Name:

Elba M. Stephens

Association:

Parent Legal Guardian

Address:

21205 NE 37th Ave #603  
Aventura FL 33180

(Please use the front and back of this sheet to provide your information.)

I am the mother & legal guardian of  
my son John T. Stephens Jr.  
Severely autistic w/ seizure problems  
& severe self abusive behavior.  
He is living in a facility  
with behavior programs & other  
medical therapeutic serv. given  
by Medicaid. The group home is

a behavioral ~~and~~ facility that stresses on behaviors for those who are felt abusive like my son. His limitations on his ~~low~~ verbal communication make me his voice and I opposed Medicaid reform.

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Name: Cable A. Shapiro  
Association: National Alliance for the Mentally Ill  
Address: 18117 102 Way South  
Boca Raton, Florida 33498

(Please use the front and back of this sheet to provide your information.)

*she is a Medicaid recipient.*  
My daughter had her first episode  
during her last year of student teaching.  
at that time she was diagnosed with  
Schizo Affective. She was put on the old  
medications. For twelve years, she  
just existed. She slept all day, up all  
night. She had few friends. She hardly  
left her apartment. A year ago she  
was put on the latest <sup>best</sup> medication  
and a miracle happened.

She became, as she was before her first  
break. She has gone back to college  
to get her degree in Teaching, and is  
very active in her daily life with  
friends and community service.

Please, please do not take the new  
medications away from her. Give her  
a chance to see the light at the  
end of the tunnel. Give her back her  
hope, her soul & her life.

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Name:

Rosemary Renberg

Association:

SELF

Address:

5274 NE 6<sup>th</sup> Ave  
ORLANDO PK. Fla 33334

(Please use the front and back of this sheet to provide your information.)

I am a single disabled mother of 2 girls  
Ages 13 + 15. I have been disabled for approx 6 yrs  
collecting Medicaid benefits for my self + my girls  
And "Thank God" for this program! I am  
sure if we didn't have the benefits  
of Medicaid I wouldn't be alive today.  
Please Please do not cut this program  
or make it any more difficult

than it already is.

I recently heard on T.V. of a  
trial program for the children's  
(I think dental, but not sure if medical)

The persons involved in this trial were  
on T.V. practically crying - saying  
the "wait" for appointments WAS  
~~ASTON~~ BAZARR-terrible-SAD.

Just because we are poor  
due to unjust illness doesn't  
mean our children and selves should  
suffer any more than  
we already do!!!  
Please Please

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**Name:** Dr. L. H. T. SPITASANNM M.D. F.A.P.

**Association:** \_\_\_\_\_

**Address:** 1319 SE 2nd Ave  
FT. LAUD. FLA

(Please use the front and back of this sheet to provide your information.)

I am a pediatrician practicing in Broward County. The Medicaid  
reform program of handing over Medicaid dollars to HMO's  
will spell utter disaster. The only people who benefit from  
such program is the CEO, COO & CFO's of the med-aid /  
HMO's. Patients suffer enormously as is the case  
now I may HMO medicaid who don't provide  
necessary services or medications. This is even  
worse so for patients I special needs & psychiatric illness

especially for children. If the reforms  
go through it will be a sad day for the  
underprivileged children of India & will be  
a sad day for democracy. I hope the  
Committee will take into full consideration  
of all pros & cons before coming to any  
decision

Thank you

Dr. Sahoo

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Name: Lou Ferrari  
Association: PAH TRAN CONNECTION  
Address: 3040 S. Military Trail  
Lake Worth FL 33463

(Please use the front and back of this sheet to provide your information.)

I would like to urge the Legislatures to keep  
the Non-Emergency Medicaid Transportation Program under  
the Transportation Disadvantaged Commission. The TD  
Commission gives the Medicaid Transportation beneficiaries the  
best option for their transportation. If moved the <sup>Public</sup> Transportation  
system in the state of Florida would be in disarray.

Thank you.

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**Name:** Richard T. Labonski

**Association:** self

**Address:** 2320 S. Cypress Bend Dr #106  
Pompano Beach FL 33069

(Please use the front and back of this sheet to provide your information.)

I am the adoptive parent of a 14 year old boy with multiple  
disabilities which include autism and cerebral palsy. At age 62,  
there are only a few more years during which I expect to be able  
to care for him. There is no one else left to care for Jimmie.

In a society that professes a respect for life, I find it  
incredible that the focus is only on controlling costs, without  
looking for appropriate ways to enhance revenues, perhaps  
through taxation.

Thanks  
99 Richard J. Labonski 2/14/05